

## MEDICAL CERTIFICATION

DHMH - 16 60M 7/B4  
(VRA 15, 4)

10-21-61

10-21-61

10-21-61

WASHINGTON D.C. 20540  
U.S. POST OFFICE  
10-21-61

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

33209

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Clifton

Stefan

Ahmad, Jr.

2a. DATE KNOWN OF DEATH ☒ ESTI. MATED ☐ MONTH DAY YEAR HOUR  
11 26 19 87 M  
2c. DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR  
11 26 19 87 M 8:05A

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

Month DAY YEAR  
Maryland

6 AGE (IN YEARS)

05

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County MD.

10 CITY OR TOWN OF DEATH

Seat Pleasant

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

203 69th Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

None

12b. KIND OF BUSINESS OR INDUSTRY

None

13a. STATE

Maryland

13b. COUNTY

P.G.

13c. CITY OR TOWN

Seat Pleasant

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

203 - 69th Street

14 FATHER'S NAME

Clifton S. Ahmad, Sr.

15. MOTHER'S MAIDEN NAME

Tracy Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

None

17 INFORMANT

ADDRESS

Tracy Williams - same as item #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Smoke and soot inhalation

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
8 11 26 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

House fire

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

home

21f. LOCATION

203 69th St.

CITY OR TOWN

COUNTY

STATE

Seat Pleasant, P.G., MD

22a I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: (Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐)

ACTUAL SIGNATURE

*Mario F. Golle, Jr.*

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE SIGNED

11/27/87

EXAMINER'S NAME (TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS

111 Penn St.

Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-1-87

23c. NAME OF CEMETERY OR CREMATORY

Lincoln Cemetery

23d. LOCATION

Suitland, Md.

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

ADDRESS

Vann & Williams, 4804 Ga. Ave., N.W.-Wash., D.C.

25a. DATE REC'D. BY REGISTRAR

12-2-87

25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

13700 11-30

SEP 11 1941

1000

1000

1000

1000

1000





073753 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-1. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Justin

Lamar

Ahmad

2a. DATE KNOWN  
OF DEATH ESTI-  
MATED ☒ MONTH DAY YEAR

11 26 19 87

2b. HOUR  
M

3 SEX

Male

4 RACE

Black

5. DATE OF BIRTH

Dec. 14, 1983

6. AGE (IN YEARS)

04 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE

PRONOUNCED  
DEAD

11 26 19 87

2d. HOUR  
8:05A  
M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County

MD

10. CITY OR TOWN OF DEATH

Seat Pleasant

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
203 69th Street12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

None

12b. KIND OF BUSINESS  
OR INDUSTRY

None

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

P.G.

13c. CITY OR TOWN

Seat Pleasant

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

203 - 69th Street

14. FATHER'S NAME

Clifton

MIDDLE

Stefan

LAST

Ahmad

15. MOTHER'S MAIDEN NAME

Tracy

MIDDLE

Rochelle

LAST

Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)  
No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)  
None

17. INFORMANT

ADDRESS

Tracy Williams - same as item #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

8902

IMMEDIATE CAUSE (a). Smoke and soot inhalation

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
8 PM 11 26 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

House fire

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

home

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE  
203 69th St., Seat Pleasant, P.G. Co, MD.

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL  
SIGNATURE

Mario F. Golle, Jr.

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 11/27/87

EXAMINER'S NAME  
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS 111 Penn St. Balto, MD.

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)  
Burial

23b. DATE

12-1-87

23c. NAME OF CEMETERY OR CREMATORY

Lincoln Cemetery

23d. LOCATION

Suitland, MD

CLOSING

F. J. Williams

24. FUNERAL DIRECTOR

Vann &amp; Williams Funeral Home, 4804 Ga. Ave., N.W., Wash., D.C.

DATE RECORDED BY REGISTRAR'S SIGNATURE

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

01-23-2003 09:00:00

073755 DEC

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Shenna Nichelle Ahmad								<input checked="" type="checkbox"/>		11		26		19		87	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Black	Dec. 10, 1985		01		MONTHS		DAYS		11		26		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Prince George's County MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Seat Pleasant		203 69th Street										None		None			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		P.G.		Seat Pleasant		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		203 - 69th Street 20743									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				17. INFORMANT ADDRESS									
Clifton S. Ahmad, Sr.				Tracy Williams				Tracy Williams - same as item #13									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
No				None													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Smoke and soot inhalation																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
8 PM 11 26 87				House fire													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
home				203 69th St.,				Seat Pleasant, P.G. Co, MD.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Mario F. Golle, Jr.				Assistant				11/27/87									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Mario F. Golle, Jr., M.D.				111 Penn St. Balto.MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				12-1-87				Lincoln Cemetery				Suitland, Md.					
24. FUNERAL DIRECTOR'S NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
William & Williams, 4804 Ga. Ave., N.W., Wash., D.C.								DEC 02 1987				Julia Davidson					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM-1. GIVE PAGES 5 AND 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 5 AND 6 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND-21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

013512 100-385

RECEIVED  
FEB 10 1964



073085 NOV 25 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN ALLEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 14 87</b>		2b. HOUR <b>2 20 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 14 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S MD</b>
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S HOSPITAL CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Capitol Heights</b>		13d. INSIDE CITY LIMITS? <b>NO</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Bates</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Allen</b>		16. STREET ADDRESS / ZIP CODE <b>1100 Booker Drive 20743</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>709 12 4759</b>		17. INFORMANT ADDRESS <b>Robert Allen-son-1100 Booker Drive</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>History of Ca of lung &amp; metastasis to liver</b>						
9a. DATE OF OPERATION <b>11-12-1987</b>		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINERS)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11-12-1987</b> to <b>11-14-1987</b> , that (I) (we) lost saw the deceased alive on <b>11-13-1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>N. S. Dhalwal</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11-16-87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KARINDER S. DHALWAL</b>				22e. ADDRESS <b>Prince George's General Hospital &amp; M.C. Cheverly, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 20 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>John T. Stewart III</b> <b>Stewart Funeral Home-4001 Benning Road, N.E.</b>				25a. DATE REC'D BY REGISTRAR <b>NOV 24 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Friedman-Randall</i>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon paper (pages 1 and 2) and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Amelia Olson ANDERSON			2a. DATE OF DEATH November 8, 1987			2b. HOUR 1:50p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH February 6, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 94		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.			12a. USUAL OCCUPATION (NATURE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8308 Donoghue Drive 20784	
14. FATHER'S NAME August Olson			15. MOTHER'S MAIDEN NAME (Unavailable)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 501-44-1816			17. INFORMANT (Daughter) Marion A. Johnson			8308 Donoghue Drive New Carrollton, Md. 20784			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 11/8/87 to 11/9/87, that (1) we last saw the deceased alive and above (1) we did not see the body after death.									
22b. SIGNATURE William D. Rosson						22c. DATE SIGNED 11/9/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. ROSSON, M.D.						22e. ADDRESS 5701 - 85th Ave., New Carrollton, Md. 20784			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-14-87		23c. NAME OF CEMETERY OR CREMATORY Alma Baptist Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arggle Marshall Minnesota		
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

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072581 NOV 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33214  
2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR 11-5 19 87  
2b. HOUR M  
2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-5 19 87  
2d. HOUR M  
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Blanche J. Anderson3. SEX Female 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR Sept. 19. 1916 7 P.M.  
6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

10. CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince George's Gen. Hosp. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.

13a. STATE Md. 13b. COUNTY P.G. 13c. CITY OR TOWN Landover 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 6817 Forest Terr. 20784

14. FATHER'S NAME FIRST MIDDLE LAST George Long 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 577-60-5894 17. INFORMANT ADDRESS Joseph W. Long-3821 17th Pl., N.E.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Old right-leg amputation, and gastrectomy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED 11-5-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

11/10/87

23c. NAME OF CEMETERY OR CREMATORY

FT. LINCOLN CEM.

23d. LOCATION CITY OR TOWN

BLADENSBURG, MD.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

H. S. WASHINGTON &amp; SONS 4925 BURROUGHS AVE., N.E.

25a. DATE REC'D. BY REGISTRAR

NOV 19 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
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(VR A15 ME (5))

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Elsie Lorraine APOISKI</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 25, 1987</b>		2b. HOUR <b>4:10p. M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 2, 1907</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>80 YRS</b>	
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home, Inc.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince-Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Preston Dewey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Golden</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>577-26-7386</b>		17. INFORMANT ADDRESS <b>12911 Kendate Lane, Bowie, Maryland 20715</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 24</u> , 19 <u>87</u> , to <u>11-25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-23-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John N. Kehoe M.D.</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-24-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN N KEHOE</b>		22e. ADDRESS <b>6300 Riverdale Rd. Riverdale</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-28-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Arlington, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>			
24. FUNERAL DIRECTOR <b>FRANCIS GASCHS SONS FUNERAL HOME, P.A.</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodgers</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, and medical certificate must be notified to the

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

DEC 03 1981

TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or letter.]

DEC 03 1981  
FBI - NEW YORK

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 2 1 6

FOR  
STATE  
REGISTRAR

REG. NO.

073297 NOV 27 87

1. DECEASED NAME (TYPE OR PRINT) James Murile Arnold			2a. DATE OF DEATH MONTH DAY YEAR 11-15-87		2b. HOUR 10:10AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1943		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Upper Marlboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8510 James Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY James Arnald Inc
13a. STATE Maryland	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8510 James Street 20772	
14. FATHER'S NAME FIRST MIDDLE LAST James E. Arnold		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcella L. Beavers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES) N/A	16b. SOCIAL SECURITY NO. 213-40-7433	17. INFORMANT Joyce Arnold Same as 13 a-e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic carcinoma</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/30/87 to 11/15/87, that (I) (we) last saw the deceased alive on 10/30/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Martino D. Wultz		DEGREE M.D.		22c. DATE SIGNED 11/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martino D. Wultz		22e. ADDRESS Greenway Dr One Greenbelt 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (CITY OR TOWN) COUNTY STATE Clinton Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. Old Alexander Ferry Rd. Clinton, Md.		25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE Julia Bender-Randall	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PD-1000. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <b>Josephine Elizabeth</b>				2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>26</b> YEAR <b>1987</b>				2c. HOUR <b>11:50 PM</b>	
3. SEX <b>F</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Aug. 5, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2d. DATE PRONOUNCED DEAD <b>11 26 1987</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>				2e. HOUR <b>11:50 PM</b>	
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>PRINCE GEORGE</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5805 42nd AVE #220</b>			
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Francis Williamson</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Pauline Lillian Pherrell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-09-6459</b>		17. INFORMANT <b>4802 Gallatin Street, Hyattsville, Mrs. Helen Patrick, Maryland 20781</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOCLEROTIC CARDIOVASCULAR DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1 hour</b> <b>YEARS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>N/A</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Paul A. DeVore</b>		TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>11/27/87</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL A. DE VORE, M.D.</b>		ADDRESS <b>4203 QUEENSBURY RD HYATTSVILLE MD 20781</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>					
24. FUNERAL DIRECTOR <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>							
4739 Baltimore Ave., Hyattsville, Maryland											

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072014 NOV 17 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33218  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
James L.		Baker, Jr.						Oct 16 1987								A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	Blk	Dec. 19 37		49 YRS.						Oct 16 1987						A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
D.C.		U.S.A.						Prince Georges								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS											
Riverdale		Leland Memorial Hosp		Roofers		Improvement											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		Prince Georges		N. Brentwood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3910 Allison								20722	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
James L. Baker, Sr.		Mary Williams															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		218-34-6150		Mary Murray-Same as # 13 above													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) <u></u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
<u>None</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
<u>None</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
<u>John S. Rogers, M.D.</u>		1919 Seminary Rd.				Oct 16 1987											
(TYPE OR PRINT)		ADDRESS		Silver Spring, Md.													
23. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
		10/21/87		FT. LINCOLN CEM.		BLADENSBURG P.G. MD											
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
NAME		ADDRESS															
H. S. WASHINGTON + SONS		4925 BURROUGHS AVE. NE.															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1977-11-05



073810 DEC 28

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
Herbert R. BALKCUM2a DATE OF DEATH MONTH DAY YEAR 2b HOUR  
11-27-87 1:30 AM

3 SEX

male

4 RACE

WHITE

5 DATE OF BIRTH

MONTH DAY YEAR  
8 26 26

6 AGE (IN YEARS LAST BIRTHDAY)

61 YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

N. CAROLINA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges MD.

10 CITY OR TOWN OF DEATH

Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Southern Maryland Hospital

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
REPRESENTATIVE

12b KIND OF BUSINESS OR INDUSTRY

SCHOOL ART INSTRUCTION

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md.

13b COUNTY

P.G.C.

13c CITY OR TOWN

FORESTVILLE

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

7507 MARION ST. 20747

14. FATHER'S NAME

FIRST MIDDLE LAST  
JOHN L. BALKCUM

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
MACY DREW

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

YES

WWII

16b SOCIAL SECURITY NO.

243-22-5984

17 INFORMANT

JANE M. BALKCUM

ADDRESS

SAME AS ITEM #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

COPD, lung cancer

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

72 Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0

Dehydration, Malnutrition

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 11/24, 1987, to 11/27, 1987, that (I) (we) lost saw the deceased alive on 11/27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

11-27-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Michael Levine MD.

22e ADDRESS

Clinton MD  
7501 Old Branch Ave #409 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b DATE

11-28-1987

23c NAME OF CEMETERY OR CREMATORY

CHAMBERS CREMATORY

23d LOCATION

CITY OR TOWN

COUNTY

STATE

RIVERDALE, P.G.C. Md.

24 FUNERAL DIRECTOR

NAME

W. W. CHAMBERS CO.

ADDRESS

RIVERDALE, Md. 20737

25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE

DEC 02 1987 Julia Gordon-Rubens

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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072333 NOV 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

SYLVIA

Louise

BARBEE

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

11 7 87

900A  
M

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

May 18, 1938

6. AGE (IN YEARS LAST BIRTHDAY)

49

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

North Carolina

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

MD.

10. CITY OR TOWN OF DEATH

CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

PRINCE GEORGES NURSING CARE CENTER

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

n/a

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

PG

13c. CITY OR TOWN

Landover

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

6109 Osborne Rd.

20785

14. FATHER'S NAME

Matthew Godette, Sr.

15. MOTHER'S MAIDEN NAME

Cornelia Stanley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) no

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES) 238-50-0439

17. INFORMANT

ADDRESS

Donell Barbee; 6109 Osborne Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Respiratory Failure  
ACUTE RESPIRATORY FAILURE

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

HOURS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) BRAIN TUMOR

DUE TO, OR AS A CONSEQUENCE OF

(c)

&gt; 1 YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from

saw the deceased alive on

prior to (he) (she) (it) (did) (did not) see the body after death.

19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

22f. PHYSICIAN'S NAME (TYPE OR PRINT)

22g. ADDRESS

22h. PHYSICIAN'S NAME (TYPE OR PRINT)

22i. ADDRESS

22j. PHYSICIAN'S NAME (TYPE OR PRINT)

22k. ADDRESS

22l. PHYSICIAN'S NAME (TYPE OR PRINT)

22m. ADDRESS

22n. PHYSICIAN'S NAME (TYPE OR PRINT)

22o. ADDRESS

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY) Removal

23b. DATE

11-12-87

23c. NAME OF CEMETERY OR CREMATORY

Harpers Funeral Home

23d. LOCATION

CITY OR TOWN

Kalamazoo

COUNTY

Mich.

STATE

24. FUNERAL DIRECTOR

Marshall's Funeral Home

4217 9th St NW: Washington, D.C.

25. DATE REC'D BY REGISTRAR

NOV 16 1987

25b. REGISTRAR'S SIGNATURE

John D. Anderson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, leave remainder of certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "I saw the body after death," the medical examiner must be notified at once.

0 2 5 3 3 1 2 1 0 6 1

STATION  
DATE  
TIME  
PLACE

WIND  
TEMP  
HUMIDITY  
PRESSURE

WIND DIRECTION  
WIND FORCE

WIND VELOCITY  
WIND DIRECTION  
WIND FORCE

WIND VELOCITY  
WIND DIRECTION  
WIND FORCE

071056 NOV

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST VIRGINIA CORONIA BARCELON		2a. DATE OF DEATH MONTH DAY YEAR NOV 03 1987		2b. HOUR 4:54a.m.	
3. SEX Female		4. RACE Filipino		5. DATE OF BIRTH MONTH DAY YEAR June 1, 1953	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philippines		7b. CITIZEN OF WHAT COUNTRY? Philippines		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcomb Grow- AAFB Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY Library			
13a. STATE California		13b. CITY OR TOWN San Francisco		13c. STREET ADDRESS / ZIP CODE 416 Sunnydale Ave 99998	
14. FATHER'S NAME FIRST MIDDLE LAST Filadelfo Coronia		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Ernesto Barcelon Same as #13E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADULT RESPIRATORY DISTRESS SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE ORGAN FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <u>17 JUL</u> , 19 <u>87</u> , to <u>03 NOV</u> , 19 <u>87</u> , that (X) (we) lost saw the deceased alive on <u>03 NOV</u> , 19 <u>87</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE <i>Frank J. Archer</i>		DEGREE M.O. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 03 NOV 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK J. ARCHER, CAPT, USAF MC		22e. ADDRESS MG USAF MC, ANDREWS AFB, MD., 20331-5300			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-9-87		23c. NAME OF CEMETERY OR CREMATORY Polong Norte	
23d. LOCATION CITY OR TOWN COUNTY STATE Pan Gasina Philippines					
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR NOV 04 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
6633 Old Alexander Ferry Rd. Clinton, Md. 20735					

MEDICAL CERTIFICATION

1



074692 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 2 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna J. BARNES			2a. DATE OF DEATH MONTH DAY YEAR November 26, 1987		2b. HOUR 2:16A M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired LPN		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Cap. Heights	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Redmond Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Priscilla Vines			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 238-20-8068		17. INFORMANT ADDRESS Juanita Bourguillion -daughter-	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apic Abscess</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Relingian disease, irreversible</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia, Diabetic</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>84</u> to <u>Nov</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert J. Freige M.D.</u>		DEGREE		22c. DATE SIGNED <u>11/26/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. FREIGE		22e. ADDRESS <u>4410 4th Ave Landover Hills, MD 20785</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 31 1987	23c. NAME OF CEMETERY OR CREMATORY Washington Natl.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD.
24. FUNERAL DIRECTOR NAME Stewart		Funeral Home 4001 Benning Road,		25a. DATE REC'D. BY REGISTRAR DEC 10 1987	
25b. REGISTRAR'S SIGNATURE					

BP

03465 5 111125

RECEIVED

Robert A. Stewart III



051274 NOV 15 03

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071806 NOV 16 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE/  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33224

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
Earl Leroy Barrett								11/12 87		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		8.25	
Male	White	Aug. 8, 1926		61 YRS.				11/12 87		A. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		United States				Prince George's County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Glendale		12004 Fairway Court				Manager		Elec. Cont.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Prince George's		Glendale				12004 Fairway Court		20769	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Notley H. Barrett				Helen Corrine Perrie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WW II		577-30-3877		Mary E. Barrett, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
None											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
				M.D. Deputy				11/12/87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
John S. Rogers, M.D.				1919 Seminary Road Silver Spring, Montgomery County, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Nov. 16, 1987		Gate of Heaven Cemetery		Silver Spring, Maryland					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Beall Funeral Home				16000 Annapolis Rd. Bowie, MD 20715		NOV 13 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
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(VR A15 ME (5))

17180-2 NOV 19 57

Male White Aug. 3, 1920  
12001 Falmouth Court  
12001 Falmouth Court  
12001 Falmouth Court

None myocardial disease.

None

None

None

John L. Roberts, M.D.  
1919 Secretary  
1919 Secretary

NOV 1 2 1957

073211

NOV 27 1987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY Ford BAUMGARDNER			2a. DATE OF DEATH MONTH DAY YEAR 11-19-87			2b. HOUR 12.05A <sub>M</sub>			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME John W. Baumgardner			15. MOTHER'S MAIDEN NAME Belle Warnock			16. STREET ADDRESS / ZIP CODE 7227 Maryland Street 20784			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234-05-5019		17. INFORMANT (Wife) Electra Baumgardner Hyattsville, Md. 20784				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uro Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Comatose</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse intra cerebral bleeding</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19 <u>87</u> , to <u>11/8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert J. Gereige</u> M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. GEREIGE						22e. ADDRESS 4410 74th Ave Landover Hills MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/21/87		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi P.G. Maryland		
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>John B. B. B. B.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE  
REGISTRAR

Joseph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST <b>JAMES J. BEACOM</b>		MONTH DAY YEAR <b>November 23, 1987</b>		12:52A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR <b>January 3, 1936</b>	51 YRS.	MONTHS	DAYS
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
(STATE OR FOREIGN COUNTRY) <b>Maryland</b>	<b>U.S.A.</b>	<input checked="" type="checkbox"/> MARRIED	<input type="checkbox"/> NEVER MARRIED	<b>Prince George's County</b>	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY		
<b>Lanham</b>	<b>Doctor's Hospital of P.G. County</b>	(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookbinder</b>	<b>G.P.O.</b>		

13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
<b>Maryland</b>		<b>P.G.</b>	<b>Lanham</b>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>9895 Goodluck Road 20706</b>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST <b>James J. Beacom</b>		FIRST MIDDLE LAST <b>Mary G. McGrogran</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	17. INFORMANT		
(YES, NO OR UNKNOWN) <b>Yes-Navy</b>		(IF YES, GIVE WAR OR DATES) <b>Korean</b>	<b>(Wife) 9895 Goodluck Road</b>		
		<b>578-46-6081</b>	<b>Helen J. Beacom Lanham, Maryland 20706</b>		

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b>		
DUE TO, OR AS A CONSEQUENCE OF (c)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/19/87</u> to <u>11/23/87</u> , that (I) (we) last saw the deceased alive on <u>11/23/87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			
22b. SIGNATURE <b>William D. Rosson</b>			22c. DATE SIGNED <b>11/24/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. William D. Rosson, M.D.</b>			22e. ADDRESS <b>5701 85th Avenue, New Carrollton, Md. 20784</b>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
<b>Burial</b>	<b>11/27/87</b>	<b>Fort Lincoln Cemetery</b>	<b>Brentwood P.G. Maryland</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
<b>4739 Baltimore Avenue Hyattsville, Md. 20781</b>		<b>DEC 02 1987</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 78 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR2. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
CHARLES LYMAN BEALL2a. DATE OF DEATH MONTH DAY YEAR  
November 22, 19872b. HOUR  
4:41A M3. SEX  
Male4. RACE  
White5. DATE OF BIRTH  
MONTH DAY YEAR  
Nov. 30, 1905<sup>AR</sup>6. AGE (IN YEARS LAST BIRTHDAY)  
81IF UNDER 1 YEAR IF UNDER 24 HRS  
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN  
COUNTRY)  
Maryland7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH  
Prince George's County MD10. CITY OR TOWN OF DEATH  
Cheverly11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Prince George's General Hospital12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Baker12b. KIND OF BUSINESS OR INDUSTRY  
Continental Baking Company

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland13b. COUNTY  
P.G.13c. CITY OR TOWN  
Bladensburg13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS / ZIP CODE  
5999 Emerson Street #922 2071014. FATHER'S NAME  
FIRST MIDDLE LAST  
Glennwood Beall15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Minnie Mockabee16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
Yes- Navy W.W.II16b. SOCIAL SECURITY NO.  
578-09-675817. INFORMANT  
5999 Emerson Street #922  
Bladensburg, Md. 2071018. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Parkinson's disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
4:41 AM 11 22 8721c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  
Coronary artery disease

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
Home21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from 8-13- 1985 to 11-22 1987, that (I) (we) lost  
saw the deceased alive on 11-20- 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

John Kehoe, M.D.

22e. ADDRESS

6300 Riverdale Road Riverdale, Md. 20737

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)  
Burial23b. DATE  
11/25/8723c. NAME OF CEMETERY OR CREMATORY  
Fort Lincoln Cemetery Brentwood23d. LOCATION  
CITY OR TOWN COUNTY STATE  
P.G. Maryland

24. FUNERAL DIRECTOR

Francis Casch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DEC 02 1987 Julia Davidson-RodneyTO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Page 1 should be filed with the State Dept. of Health and Mental Hygiene. Page 4 should be filed with the State Dept. of Health and Mental Hygiene. Page 5 should be filed with the State Dept. of Health and Mental Hygiene. Page 6 should be filed with the State Dept. of Health and Mental Hygiene. Page 7 should be filed with the State Dept. of Health and Mental Hygiene. Page 8 should be filed with the State Dept. of Health and Mental Hygiene. Page 9 should be filed with the State Dept. of Health and Mental Hygiene. Page 10 should be filed with the State Dept. of Health and Mental Hygiene. Page 11 should be filed with the State Dept. of Health and Mental Hygiene. Page 12 should be filed with the State Dept. of Health and Mental Hygiene. Page 13 should be filed with the State Dept. of Health and Mental Hygiene. Page 14 should be filed with the State Dept. of Health and Mental Hygiene. Page 15 should be filed with the State Dept. of Health and Mental Hygiene. Page 16 should be filed with the State Dept. of Health and Mental Hygiene. Page 17 should be filed with the State Dept. of Health and Mental Hygiene. Page 18 should be filed with the State Dept. of Health and Mental Hygiene. Page 19 should be filed with the State Dept. of Health and Mental Hygiene. Page 20 should be filed with the State Dept. of Health and Mental Hygiene. Page 21 should be filed with the State Dept. of Health and Mental Hygiene. Page 22 should be filed with the State Dept. of Health and Mental Hygiene. Page 23 should be filed with the State Dept. of Health and Mental Hygiene. Page 24 should be filed with the State Dept. of Health and Mental Hygiene. Page 25 should be filed with the State Dept. of Health and Mental Hygiene. Page 26 should be filed with the State Dept. of Health and Mental Hygiene. Page 27 should be filed with the State Dept. of Health and Mental Hygiene. Page 28 should be filed with the State Dept. of Health and Mental Hygiene. Page 29 should be filed with the State Dept. of Health and Mental Hygiene. Page 30 should be filed with the State Dept. of Health and Mental Hygiene. Page 31 should be filed with the State Dept. of Health and Mental Hygiene. Page 32 should be filed with the State Dept. of Health and Mental Hygiene. Page 33 should be filed with the State Dept. of Health and Mental Hygiene. Page 34 should be filed with the State Dept. of Health and Mental Hygiene. Page 35 should be filed with the State Dept. of Health and Mental Hygiene. Page 36 should be filed with the State Dept. of Health and Mental Hygiene. 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1973-07-01

(1)

DEC 03 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA MAE BEATON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 14 87</b>		2b. HOUR <b>1;55am</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 9 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES MD.</b>
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Ft. Washington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1529 Tucker Rd. 20744</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Shockency</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna McDonald</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-22-3442</b>		17. INFORMANT ADDRESS <b>1529 Tucker Rd. Ft. Washington, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastrointestinal Bleeding</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Chronic Renal Failure</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>Nov. 5</b> , 19 <b>87</b> , to <b>Nov. 14</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Nov. 13</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Cyrus Nemati</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/14/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CYRUS NEMATI M.D.</b>				22e. ADDRESS <b>3611 Branch Ave. Temple Hills, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/18/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>				25a. DATE REC'D BY REGISTRAR <b>NOV 18 1987</b>		
ADDRESS <b>Oxon Hill, Md.</b>				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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NOV 18 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DIANA BELL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 24, 1987</b>		2b. HOUR <b>11:31 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 30, 1950</b>	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County, MD</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disability</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		13a. STREET ADDRESS / ZIP CODE <b>188 Daimler Drive (20743)</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Capitol Hgts</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Bell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Essie Dent</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>n/a</b>		17. INFORMANT ADDRESS <b>Capitol Heights, Maryland Essie Bell (mother) 188 Daimler Drive;</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure, Necrotic Bowel</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory &amp; Renal + Respiratory Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Seizure disorder.</b>					
19a. DATE OF OPERATION <b>11/6/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Necrotic Bowel</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> 19 <b>87</b> , to <b>11/24</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/24</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John Margolis MD</b>		DEGREE		22c. DATE SIGNED <b>11/25/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John MARGOLIS MD</b>		22e. ADDRESS <b>14333 Laurel Dune Rd Ste 307 Laurel, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/01/87</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Memorial Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, P.G.CO. Maryland</b>		24. FUNERAL DIRECTOR NAME <b>LATNEY's Funeral Home</b>			
25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

1901 57 5732

X



Item 6 Film G633 11-24-87 SB

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- per funeral home  
FOR STATE REGISTRAR2- DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Margaret WILHELMINA BENNETT

2a. DATE OF DEATH MONTH DAY YEAR  
November 7, 1987  
2b. HOUR  
12:45<sup>A</sup> M

3. SEX

Female

4 RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR  
July 17, 1918

6 AGE (IN YEARS LAST BIRTHDAY)

-70- 69 YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington D.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's MD

10. CITY OR TOWN OF DEATH

Lanham

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Doctors Hospital

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Assembler

12b. KIND OF BUSINESS OR INDUSTRY

Litton Ind.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince Geo.

13c. CITY OR TOWN

College Park

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

5010 Roanoke Place, 20740

14. FATHER'S NAME

Edward

MIDDLE

LAST

Green

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST

Vermillion

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

578-05-7445

17 INFORMANT ADDRESS  
8518 60th Place, Berwyn Heights,

Mary C. Myrick, Maryland 20740

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4 hours

DUE TO, OR AS A CONSEQUENCE OF

(b)

Pulmonary Embolism

4 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Metastatic Adenocarcinoma

1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from 11 Dec 86 to 7 Nov 87, that (1) (we) lost  
saw the deceased die on 7 Nov 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
or (2) (we) did not see the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIANMEDICAL  
DIRECTOR ☒STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

11/7/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

11-10-87

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d. LOCATION  
CITY OR TOWN

Brentwood, P.G., Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

FRANCIS GASCH'S SONS FUNERAL HOME, P.A.

4739 Baltimore Ave., Hyattsville, Maryland

25a. DATE REC'D. BY REGISTRAR

NOV 10 1987

25b. REGISTRAR'S SIGNATURE

www.kandace

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages hand 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma to the patient, the medicolegal examiner must be notified at once.

051253 104-15-01

12024  
2024 NOV 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STEVE BERNARD BERISH					2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 13 1987			2b. HOUR 10:20AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 24 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR. GEO.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CO. Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY Mining			
13a. STATE Pa.		13b. COUNTY Fayette		13c. CITY OR TOWN Smithfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RD 3 Box 32 15478			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Berish		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna (Unkown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)							
16b. SOCIAL SECURITY NO. 159-16-6088		17. INFORMANT 3356 Wye Mills South Tom Berish Laurel, Md. 20707									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Codens. Carcinoma Stomach.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>liver metastatic lesions.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stenotic Aorta.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>unclimbline</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 9</u> 19 <u>87</u> to <u>Nov 13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Nov 12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-13-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CIRLO R. MONTANEZ MD			22e. ADDRESS 2308 Dodge PK Rd Landover MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/18/87		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery			23d. LOCATION Fairchance Fayette Pa.			
24. FUNERAL DIRECTOR 7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20707			25a. DATE RECD. BY REGISTRAR NOV 16 1987			25b. REGISTRAR'S SIGNATURE					

1. The following information was obtained from the records of the  
 2. Department of the Interior, Bureau of Land Management, on the  
 3. subject of the above-captioned matter.  
 4. The land in question is located in the  
 5. State of California, County of [redacted], and is  
 6. situated in the [redacted] Section, Township of [redacted],  
 7. Range of [redacted].  
 8. The land is owned by [redacted] and is  
 9. subject to a [redacted] interest.  
 10. The [redacted] interest is held by [redacted]  
 11. and is subject to the [redacted] of the  
 12. [redacted] of the [redacted] of the  
 13. [redacted] of the [redacted] of the  
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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Pansy Foust BIERLY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 2 1987</b>		2b. HOUR <b>11:35 P</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18, 1894</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.		10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Analyst</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		13. STREET ADDRESS / ZIP CODE <b>6411 Adelphi Road, 20782</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Foust</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate Louise Robinson</b>		16. SOCIAL SECURITY NO. <b>579-22-4431</b>		
17. INFORMANT <b>Robert Bierly, Rockville, Md. 20850</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute stroke</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>One day</b> <b>Unknown</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Diabetes mellitus II. Renal insufficiency. Anemia</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>28 October 1974</b> to <b>2 November 1987</b> , that (I) (we) last saw the deceased alive on <b>2 November 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Carl J. Houmann</i>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2 Nov., 1987</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carl J. Houmann, M. D.</b>		22e. ADDRESS <b>4404 Queensbury Rd., Riverdale, MD 20737</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-05-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cem. Adelphi, P.C., Maryland</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi, P.C., Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 06 1987</b>				
23f. REGISTRAR'S SIGNATURE <i>Wanda Randall</i>		23g. REGISTRAR'S SIGNATURE <i>Wanda Randall</i>				

TO FUNERAL DIRECTOR

FRANCIS GASCHS SONS FUNERAL HOME, P.A.  
4739 Baltimore Ave., Hyattsville, Md.

DATE REC'D. BY REGISTRAR

REGISTRAR'S SIGNATURE

NOV 06 1987

Wanda Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MARY			MIDDLE BLAKE			LAST		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH September 22 1891		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wake County NC			7b. CITIZEN OF WHAT COUNTRY? United States of America			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CLINTON MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
13a. STATE MD			13b. COUNTY P.G.			13c. CITY Landover		
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL ROGERS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ROGERS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. UNAVAILABLE			17. INFORMANT Rev. Doctor George Blake - SON - 2724 KELLNER DRIVE, LANDOVER MD 20785			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Renal failure - AS BR - UTI - Pyeloma</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/18</u> 19 <u>87</u> to <u>11/21</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>R. R. Bacon</u>						22c. DATE SIGNED 11/21/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. R. Bacon</u>						22e. ADDRESS <u>4235 26th St NW MD 20746</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>November 28 1987</u>			23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY Memorial Cemetery, Landover MD 20785</u>		
24. FUNERAL DIRECTOR NAME <u>W. H. BACON FUNERAL HOME</u> <u>3447 14th Street NW Washington D.C.</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 24 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Henderson</u>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLGA Blankenship		2a. DATE OF DEATH MONTH DAY YEAR 11-04-87		2b. HOUR 4:47P M	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 09 09 00		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN) Washington DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (IF OVER 15 YEARS OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Up Marlboro	
14. FATHER'S NAME FIRST MIDDLE LAST Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579 07 0380B		17. INFORMANT ADDRESS Frederick Blankenship Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Bilateral Pneumonia, Urinary tract infection</u>					
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-3, 1987</u> , to <u>11-4, 1987</u> , that (I) (we) lost saw the deceased alive on <u>11-4, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>N S Dhaliwal</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11-5-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NARINDER S. DHALIWAL</u>		22e. ADDRESS <u>P.G.-G. H. &amp; M. C. Cheverly, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>7 Nov 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION <u>Suitland</u>		23e. COUNTY <u>Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Robert E Wilhelm</u>		ADDRESS <u>Suitland Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 10 1987</u>	
25b. REGISTRAR'S SIGNATURE <u>Frederick Blankenship</u>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic or non-natural cause, a coroner or medical examiner must be notified at once.

MEDICAL CERTIFICATION

NOV 15 1954

BLACKBURN

THE LANCET

NOV 15 1954

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH


REG. NO.


3 3 2 3 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Delia I. Bley			2a. DATE OF DEATH MONTH DAY YEAR November 2, 1987		2b. HOUR 5:20 A <sub>M</sub>
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 19, 1987		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Ft. Washington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ft. Washington Rehabilitation Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince George	13c. CITY OR TOWN Ft. Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Louis Dschuden			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Meyers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 050-12-2487-D		17. INFORMANT ADDRESS 2510 Kingsway Rd. Paul R. Bley Ft. Washington, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson Disease, Diverticulosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (PERSON) attended the deceased from Dec. 29 1981 to Nov 2 1987, that (I) (X) saw the deceased alive on Oct 26 1987, and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did not) view the body after death.			
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank M. Ryan, M.D.		22e. ADDRESS 9401 Indian Head Highway Ft. Washington, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11/2/87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 5 1987	25b. REGISTRAR'S SIGNATURE 

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

071016-83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST CHARLES Glen BOGAN			2a. DATE OF DEATH MONTH DAY YEAR 11/14/87		2b. HOUR 10 <sup>10</sup> P. M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR September 17, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maitre'd	12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Wash., D.C.		13b. CITY OR TOWN Wash., D.C.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 4884 MacArthur Blvd. NW/20007	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-4608		17. INFORMANT 733 15th St. NW #926 Margaret Beller Washington, D.C. 20005	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Pul. Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>As old - old M. - C. I. Insufficiency</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>86</u> , to <u>11/14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. S. Z. A. Mostaan</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. S. Z. A. Mostaan		22e. ADDRESS 4235 26th Ave NW 20745			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Nov 20, 1987	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. Clinton, Md.			25a. DATE REC'D. BY REGISTRAR DEC 03 1987		
			25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Randall</u>		

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CONFIDENTIAL

DEC 03 1981

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ADA K BOHORFOUSH			MONTH DAY YEAR 11 22 87			205 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White	MONTH DAY YEAR 4 27 1900		87 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Alabama	USA			Prince George County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Beltsville	4243 Powder Mill Rd Beltsville 20705			homemaker		n/a		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Md	Prince George	Beltsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		same as #11 20705		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Louis W. DesPrez			Ada Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			213-54-6162		Anthony G. Bohorfoush Sr. same as #11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) METASTATIC COLON CANCER								
DUE TO, OR AS A CONSEQUENCE OF								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from JANUARY 19 85, to NOV. 22 19 87, that (1) (we) last saw the deceased alive on 11/17/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) did not view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
CHARLES BENNER						11/22/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
CHARLES BENNER			1161 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			11/25/87		Gate of Heaven Cemetery		Silver Spring Montgomery State Md.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Donald V. Borgwardt			NOV 25 1987			Julia D. [Signature]		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

013552-1115-11



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		26. HOUR					
Loree						Bowe		OF ESTI- MATED		XX				19		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female		Black		5 MONTH 6 DAY 1951		36 YRS.		MONTHS		DAYS		HOURS		MIN.		11		30		9:53	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Arkansas				U. S. A.								Prince George's County MD.									
11. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Bowie				Jerico Park Road (in woods)								Dancer				Entertainment					
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
District Columbia																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3400 C Street Southeast			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST Justus E. Bowe								FIRST MIDDLE LAST Emma Jean Johnson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS													
				432-04-4549				Arkansas Boree Tucker 5East Spruce Street Brinkley,													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Multiple stab wounds & blunt trauma of head																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b)																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				P.M. 19				Subject stabbed and assaulted													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
				unknown				unknown													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)										DATE SIGNED							
Mario F. Golle, Jr. M.D.				Assistant MEDICAL EXAMINER										11/30/87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
Mario F. Golle, Jr., M.D.				111 Penn St.										Balto.MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial				12-5-87				Haven Rest Cemetery				Brinkley, Monroe, Arkansas									
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Marzullo Funeral Service										Upperco, MD.				DEC - 7 1987							

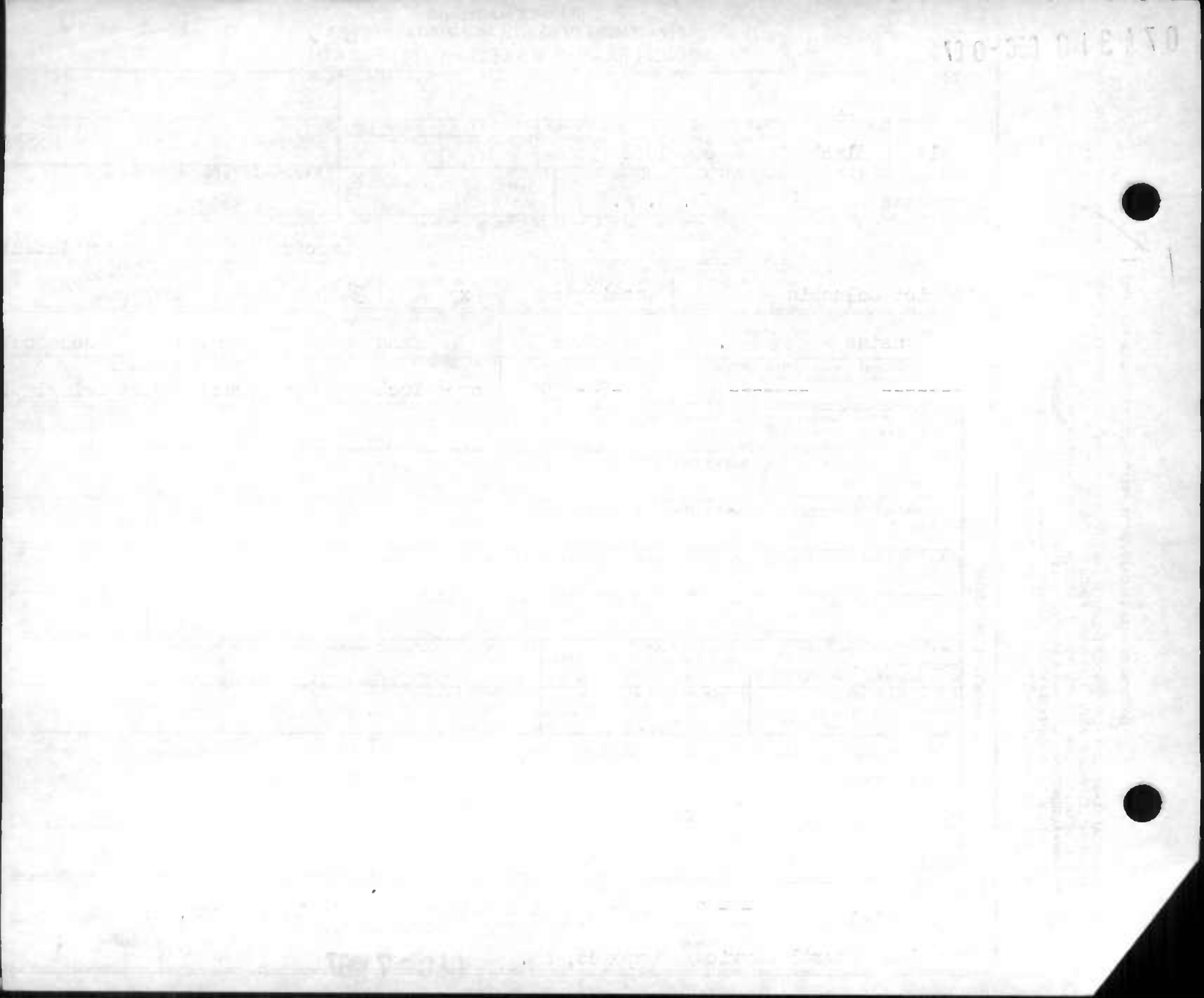
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**D MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. LEAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. MICHIGAN STREET, ANN ARBOR, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>Annie R Bowen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 24 1987</b>		2b. HOUR MIN. <b>6:15 M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 21, 1920</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Cnty</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>			
13a. STREET ADDRESS / ZIP CODE <b>Rt 224426</b>			13b. CITY OR TOWN <b>Covington</b>			
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. CITY OR TOWN <b>Covington</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Brookman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Effie Wolf</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>224 24 6155</b>		17. INFORMANT ADDRESS <b>Gary Bowen 15908 Joyce Lane, Laurel, Md</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hours.</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia. → sepsis.</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer of lung.</b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  
**DM. CHF. MI x 2.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-22-1987</b> to <b>11-24-1987</b> , that (I) (we) last saw the deceased alive on <b>11-24-1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-24-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABOUHAN R. AR</b>				22e. ADDRESS <b>14261 Laurel Park Drive Laurel, Md</b>			

23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>Nov. 27, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lone Star cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Covington, Virginia</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Donaldson Funeral Home, Laurel, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return completed pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 4).

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLIS Stanley BOWMAN			2a. DATE OF DEATH MONTH DAY YEAR 10-21-87		2b. HOUR 8:00 AM				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician		12b. KIND OF BUSINESS OR INDUSTRY U.S. Census Bureau	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 16105 Village Drive, West/20772	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1952-1954		17. INFORMANT 16105 Village Dr., West, Upper Marlboro, Md. 20772					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LIVER FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>METASTATIC GASTRIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GASTRIC CARCINOMA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>?</u> <u>?</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Adult Respiratory Distress Syndrome</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GASTRIC Carcinoma</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>September 10, 1987</u> to <u>Oct. 21, 1987</u> , that (I) (we) lost saw the deceased alive on <u>10/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) did (I) did not view the body after death.									
22b. SIGNATURE <u>Patrick R. Schimpf</u>				DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/21/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PATRICK R. SCHIMPF</u>				22e. ADDRESS <u>6492 Landown Rd Landown MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10/26/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cheltenham Veterans Cem. Cheltenham (Pr. Geo's) Md.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <u>Richard A. Coleman</u>		Upper Marlboro, Md. 20772		NOV 16 1987		J. B. Davis Registrar			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



074987 DEC 15 1987

FOR  
1587  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33241

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Robert</i>		MIDDLE <i>Brice</i>		LAST <i>Brice</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11-27-87		2b. HOUR M 0044	
3. SEX <i>Male</i>	4. RACE <i>BLACK</i>	5. DATE OF BIRTH MONTH DAY YEAR JULY 4 1927		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 60		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-27-87		2d. HOUR M 0044	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>P.G.</i>				MD.	
10. CITY OR TOWN OF DEATH <i>CLINTON</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SOUTH MARYLAND HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LABORER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SELF</i>			
13a. STATE <i>M.D.</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>UPPER MARLBORO</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>15500 PEERLESS AVE</i>		<i>20772</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES L. BRICE</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MANDA BUTLER</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>578-36-6484</i>		17. INFORMANT <i>KATIE SELLMAN</i>		ADDRESS <i>15500 PEERLESS AVE. UPPER MARLBORO M.D.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Ischemic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. <i>Obesity, ethanol intake</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		M.D.		MEDICAL EXAMINER		DATE SIGNED <i>11-27-87</i>			
EXAMINER'S NAME (TYPE OR PRINT)		<i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12-1-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HARMONY CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>LANDOVER P.G. M.D.</i>					
24. FUNERAL DIRECTOR NAME		<i>WASHINGTON, D.C. 20019</i>		<i>4339 HUNT PLACE, N.E.</i>		25. DATE REC'D. BY REGISTRAR <i>DEC 07 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

ROLLINS FUNERAL HOME, INC.

014001 1215M

2  
12

014001 1215M

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014001 1215M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST Leona Ann Brill			2a. DATE OF DEATH MONTH DAY YEAR November 23, 1987		2b. HOUR 7:30PM M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 22 1902	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		
10. CITY OR TOWN OF DEATH Adelphi	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1917 Red Oak Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY PG	13c. CITY OR TOWN Adelphi	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1917 Red Oak Drive 20183	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Kingree		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine UNK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 54 8933	17. INFORMANT 2445 Lyttonville Rd. S.S. Md. Wallace J. Brill, Jr. (Son)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1/82</u> , 19 <u>82</u> , to <u>11/23/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/24/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/24/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Vivek Vaid		22e. ADDRESS 3311 Toledo Terrace #102-B Hyatts. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/27/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Maryland	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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NOV 27 1987





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVID Dudley BROCKETT					2a. DATE OF DEATH MONTH DAY YEAR 11 7 87		2b. HOUR 4.45am				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Haven Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Local 132		12b. KIND OF BUSINESS OR INDUSTRY Carpenters Union			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN LaPlata					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Hickory Lane # 313 20646				
14. FATHER'S NAME FIRST MIDDLE LAST Walter Brockett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Bel Kay		16. ADDRESS 2040 N. Vermont St. Arlington, VA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1942-1943 109-05-4975		17. INFORMANT Justine B. Owens							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD - Bronchoma</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/11, 1987, to 11/7, 1987, that (I) (we) last saw the deceased alive on 11/7, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. E. H. Mostafa</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/7/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. E. H. Mostafa						22e. ADDRESS 4235 26th Ave and 20748					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/10/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Prince George's MD.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS Old Alexander Ferry Rd Clinton, Md 20735						25a. DATE REC'D. BY REGISTRAR NOV 12 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

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071880 NOV 18

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>Sarah Thomas Brogan</b>			2b. DATE KNOWN OF DEATH EST. MATED <b>11-10-87</b>			2d. HOUR <b>8P</b>		
3 SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-1-22</b>	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>65</b>	IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11-10-87</b>		2d. HOUR <b>8P</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b>		
10. CITY OR TOWN OF DEATH <b>Suitland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3411 Andover Place</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Suitland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Isaac Milton Thomas</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Helen Apple</b>			13e. STREET ADDRESS <b>3411 Andover Place</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>240-22-4014</b>		17. INFORMANT ADDRESS <b>Virginia C. Martin 3409 Andover Pl. Suitland, Md.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic arteriosclerotic cardiovascular disease</b> DOE TO, OR AS A CONSEQUENCE OF <b>disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>	TITLE (SPECIFY) <b>Deputy</b>	M.D.	MEDICAL EXAMINER	DATE SIGNED <b>11-10-87</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/14/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Mem. Gardens</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Roanoke Roanoke Virginia</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>George P. Kalas Funeral Home Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 35 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

DHMH - 17  
(VR A15 ME (5))

071800 NOV 1961

11-10-61

11-10-61

11-10-61



11-10-61



073703 DEC-2-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33246

FOR  
1- STATE  
REGISTRAR

CEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

DONALD M. BROWN

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b. HOUR  
ESTIMATED ☐ 11/19 1987 5:40P

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR 12 31 1926

6. AGE (IN YEARS)

LAST BIRTHDAY) 60 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7c. DATE

PRONOUNCED DEAD 11/19 1987 5:40P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

South Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

~~XXXXXXXXXX~~ PG

MD.

10. CITY OR TOWN OF DEATH

Forestville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
2613 Newglan Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Automotive Spec.

12b. KIND OF BUSINESS OR INDUSTRY

Ford Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

PG

13c. CITY OR TOWN

Forestville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2613 Newglan Avenue 20747

14. FATHER'S NAME

FIRST James

MIDDLE R.

LAST Brown

15. MOTHER'S MAIDEN NAME

FIRST Nina

MIDDLE

LAST Robinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

10/53 to 10/55 248-38-1454

17. INFORMANT

ADDRESS

Amos L. Brown 1244 Florida Ave., N.E.

18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Tracheostomy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)  
M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED 11/20/87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Court  
Camp Springs, MD 20748

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11-25-87

23c. NAME OF CEMETERY OR CREMATORY

Cheltenham Maryland Cem.

23d. LOCATION (CITY OR TOWN)

Cheltenham

COUNTY

P G

STATE

MD

24. FUNERAL DIRECTOR NAME

Robert G. Mason

ADDRESS

1661 Good Hope Road, SE

25a. DATE REC'D. BY REGISTRAR

DEC 01 1987

25b. REGISTRAR'S SIGNATURE

John Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

073709 10-585

DEC 01 1958  
FBI - NEW YORK

072052 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>William Nelson Brown</b>			2a DATE OF DEATH MONTH DAY YEAR <b>November 9, 1987</b>		2b HOUR <b>4:30 A M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>March 15, 1892</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Morrisville Va</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.		
10 CITY OR TOWN OF DEATH <b>Clinton</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operator</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Transit</b>	
13a STATE <b>Maryland</b>	13b COUNTY <b>Pr George</b>	13c CITY OR TOWN <b>District Hts</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>2314 Roslyn Ave 20747</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James M Brown</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Copplee</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>578-10-6878</b>		17 INFORMANT ADDRESS <b>Joseph W Brown Same as #13</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary of left Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>6 mos</u> <u>15 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Advanced Age</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>11-8-86</u> to <u>11-8-87</u> that (I) (we) last saw the deceased alive on <u>11-8-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Mark H. Pillor</u>		DEGREE <u>M.D.</u>		22c DATE SIGNED <b>11-9-87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark H. Pillor, M.D.</b>		22e ADDRESS <b>6188 Oxon Hill #200 Oxon Hill, Md</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>11-11-87</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery Suitland</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>PG MD</b>	
24 FUNERAL DIRECTOR NAME <b>Robert E Wilhelm</b>		ADDRESS <b>Suitland, Md</b>		25a DATE REC'D BY REGISTRAR <b>NOV 16 1987</b>	
				25b REGISTRAR'S SIGNATURE <u>John Anderson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNIE G. BRUCE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 2 87</b>		2b. HOUR MIN. <b>11 05 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 18, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>prince Georges</b> MD.
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Gardner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgeanna Johnson</b>		13e. STREET ADDRESS / ZIP CODE <b>2003 Chapman Road 20783</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>578-20-9829</b>		17. INFORMANT ADDRESS <b>Marie Goff; 11550 Stuart Lane #309, SS, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure, Acute and Chronic</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Renal Failure Acute + Chronic</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks/Years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>IDIOPATHIC HYPERTROPHIC SUBAORTIC STENOSIS</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>11/1/87</b> to <b>11/2/87</b> , that (2) we last saw the deceased alive on <b>11/1/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/2/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JESSIE AD 750 GREENWAY CTR</b>		22e. ADDRESS <b>DR GREENBELT MD 20770</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-6-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Marshall's Funeral Home 4217 9th St NW: Washington, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 06 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

BP

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Handwritten notes and signatures, including a large signature at the bottom right.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME FIRST MIDDLE LAST  
ALICE WATERS Brumage  
2a DATE OF DEATH MONTH DAY YEAR  
NOVEMBER 22 1987  
2b HOUR  
4:51a M3 SEX  
Female  
4 RACE  
Caucasian  
5 DATE OF BIRTH MONTH DAY YEAR  
Feb. 7, 1913  
6 AGE (IN YEARS LAST BIRTHDAY)  
74  
IF UNDER 1 YEAR MONTHS DAYS  
IF UNDER 24 HRS. HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
New York  
7b CITIZEN OF WHAT COUNTRY?  
U.S.A.  
8 MARRIED ☐ NEVER MARRIED  
WIDOWED ☒ DIVORCED ☐  
9 BALTIMORE CITY OR COUNTY OF DEATH  
Prince George's MD.10 CITY OR TOWN OF DEATH  
Camp Springs  
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Malcolm Grow Hospital AAFB  
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Claims Admin.  
12b KIND OF BUSINESS OR INDUSTRY  
Calif. Cas. InsUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a STATE  
Maryland  
13b COUNTY  
P. G.  
13c CITY OR TOWN  
Temple Hills  
13d INSIDE CITY LIMITS?  
YES ☐ NO ☒  
13e STREET ADDRESS / ZIP CODE  
5827 Fisher Rd #12 2074814 FATHER'S NAME FIRST MIDDLE LAST  
Kent Hunter  
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Lillian Unk16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
N/A  
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  
N/A  
16c SOCIAL SECURITY NO.  
150-30-6619  
17 INFORMANT  
Brain Waters  
ADDRESS  
12908 Argyle Circle  
Ft. Washington, MD 2074418 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20a AUTOPSY?  
YES ☒ NO ☐  
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)  
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)21d INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK  
21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)  
21f LOCATION CITY OR TOWN COUNTY STATE

22a I certify that (this hospital) attended the deceased from 8 NOVEMBER 1987 to 22 NOVEMBER 1987 that (we) lost saw the deceased alive on 22 NOVEMBER 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.

22b SIGNATURE  
Ray Harman  
DEGREE  
M.D.  
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒  
22c DATE SIGNED  
22 NOV 8722d PHYSICIAN'S NAME (TYPE OR PRINT)  
JEFFERSON H. HARMAN JR. M.D.  
22e ADDRESS  
MALCOLM GROW MED CEN AAFB MD 20331-530023a BURIAL, CREMATION, REMOVAL (SPECIFY)  
Cremation  
23b DATE  
11/23/87  
23c NAME OF CEMETERY OR CREMATORY  
Lee's Crematory  
23d LOCATION CITY OR TOWN COUNTY STATE  
Clinton Prince George's Md.24 FUNERAL DIRECTOR NAME  
Lee Funeral Home, Inc.  
ADDRESS  
6633 Old Alexander Ferry Rd Clinton, Md 20735  
25a DATE REC'D. BY REGISTRAR  
NOV 25 1987  
25b REGISTRAR'S SIGNATURE  
Julia D. ...

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)





071594 NOV 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Cecelia K. Bryan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/6/87</b>			2b. HOUR M <b>5-PM</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 28 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD</b>			
10 CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hosp. Center.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE <b>9822 Green Apple Turn 20772</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Waclaw J. Kosicki</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bronislawa Michalski</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>579-68-0672</b>			17. INFORMANT ADDRESS <b>Cecelia A. Bryan 9822 Green Apple Turn Upper Marlboro, Md.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>Septic Disseminated Intravascular Coagulation</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>Nov 6 1987</b> to <b>Nov 6 1987</b> , that (1) <b>lost</b> saw the deceased alive on above, (1) <b>lost</b> and did not view the body after death, and that in (my) <b>lost</b> opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <b>Frank M. Ryan MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/6/87</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <b>9401 Irvingham High Rd Wash Md 20744</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/10/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.G. Maryland</b>		
24 FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>			ADDRESS <b>Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Denson-Randall</b>		

BP

05122 023170

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED (NAME OR PRINT)		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
		Nellie		BURKE		11/19/87				5		20		P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		a 22 04		83 YRS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
WASH. D.C.		USA				PRINCE GEORGES CO. MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
LARGO		manor care										Clerical		U S Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Maryland		Pr George		Camp Springs		YES <input type="checkbox"/> NO <input type="checkbox"/>		5319 Redd Lane 20748							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
George Fletcher				Martha Pearson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO				216-10-5672				John E Burke				Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Natural Causes</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>CVA x3, Hypertension, Bradycardia</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>RBBB, Cachexia, Depression</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]				CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>Dec 20, 1985</u> to <u>Nov. 19, 1987</u> , that (2) we last saw the deceased alive on <u>Nov. 12, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)															
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
Stuart Turkewitz				MD								11/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
Stuart Turkewitz, MD				2500 Greenway Ctr. Dr. Greenbelt, Md. 20770.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				23Nov1987		Cedar Hill Cemetery				Suitland PG Md					
24. FUNERAL DIRECTOR															
NAME Robert E Wilhelm															
ADDRESS Suitland Md.															
25a. DATE REC'D. BY REGISTRAR															
NOV 24 1987															

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13000 250000

NOVA 34 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

VIRGINIA

L.

BYNAKER

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

11

24

87

8

12P

M

3 SEX

FEMALE

4 RACE

WHITE

5 DATE OF BIRTH

MONTH

DAY

YEAR

09

11

26

6 AGE (IN YEARS LAST BIRTHDAY)

61

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Kentucky

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S

MD.

10 CITY OR TOWN OF DEATH

CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

PRINCE GEORGE'S HOSPITAL CENTER

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b KIND OF BUSINESS OR INDUSTRY

Own HOme

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

P.G.

13c CITY OR TOWN

Cheverly

13d INSIDE CITY LIMITS?

YES ☒

NO ☐

13e STREET ADDRESS / ZIP CODE

3522 56th Street

20784

14 FATHER'S NAME

Adam

MIDDLE

Smith

15 MOTHER'S MAIDEN NAME

Bettie

MIDDLE

Wicker

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

306-28-4277

17 INFORMANT (Husband) 3522 56th Street

Charles R. Bynaker Cheverly, Md. 20784

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardio-Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Pulmonary edema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

Sepsis, COPD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐

NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐

NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M.

19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 11/15/87 to 11/24/87, that (I) (we) lost

saw the deceased alive on 11/24/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Crita K. Shah MD

DEGREE

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c DATE SIGNED

11/25/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Crita K. SHAH

22e ADDRESS

Lanham, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

11/30/87

23c NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery

23d LOCATION

Brentwood

COUNTY

P.G. Maryland

24 FUNERAL DIRECTOR

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue Hyattsville, Md. 20781

25 DATE REC'D BY REGISTRAR

DEC 02 1987

26 REGISTRAR'S SIGNATURE

Julia D. Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 03 1982

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth</b>		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11-24-87</b>		26. HOUR <b>M</b>	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 23 34</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		21. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11-24-87</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Metro Supervisor Metro</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2084 3809 Thornwood Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Theodore Jones</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alma DunLap</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Toni Bailey 1906 Valley View Dr. Ft. Wash. Md.</b>							
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>Diabetic arteriosclerotic cardiac/vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Obstructive Pulmonary disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		M.D. MEDICAL EXAMINER				DATE SIGNED <b>11-25-87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct., Temple Hills, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Comer-Hodges</b>		ADDRESS <b>4901 Marlboro Pk. Bral Hills, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>				26. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

13015 REC-581

READ IN ORDER



074691 DEC 11 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE CARTER JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 29 87</b>		2b. HOUR <b>520 A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 10, 1921</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>66</b>		
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>So MARYLAND HOSPITAL CENTER</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George District Hgts.</b>		13c. CITY OR TOWN <b>2087 Addison Road, 20747</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Carter, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mandy Hart</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>255-32-8514</b>		17. INFORMANT ADDRESS <b>Mrs. Catherine Carter District Hgts.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Complete Heart Block Referred</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Occlusion of aortic coronary artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>11</b>						
19a. DATE OF OPERATION <b>11-29-87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11-29-87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11-29-87</b> to <b>11-29-87</b> , that (I) (we) last saw the deceased alive on <b>11-29-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Abulhasan Ansari</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-29-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABULHASAN ANSARI MD</b>		22e. ADDRESS <b>8922 Woodland Rd. P 2501 Clinton MD 20735</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 5, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Pk.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Stewart Funeral Home 4001 Benning Rd. NE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1987</b>		
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 3 2 5 5

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Allen

GROVER

Chambers

2b. DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
11-22-87  
2b. HOUR  
M

3. SEX

Male

4. RACE

Negro

5. DATE OF BIRTH

Aug 21 1932

6. AGE (IN YEARS)

54 RS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

2c. DATE PRONOUNCED DEAD

11-22-87

2d. HOUR

8:30 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Albemarle VA

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

MD.

10. CITY OR TOWN OF DEATH

Prince Georges

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

P.G. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Truck Driver

12b. KIND OF BUSINESS OR INDUSTRY

Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

P.G.

13c. CITY OR TOWN

Capitol Hgts

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS

1226 Benning Road #106

20743

14. FATHER'S NAME

UNAVAILABLE

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

UNAVAILABLE

ADDRESS

1226 Benning Rd

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.

Unavailable

17. INFORMANT

Dorothy Johnson

ADDRESS

1226 Benning Rd

Capitol Hgt MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

Hypertensive Cardiovascular disease

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Adipositas

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

Augusto P Rodriguez

TITLE (SPECIFY)

Deputy

M.D.

MEDICAL EXAMINER

DATE SIGNED

11-22-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS 5009 Rayburn Ct, Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

Nov 29 1987

23c. NAME OF CEMETERY OR CREMATORY

FAMILY CEMETERY, NEW HOPE, Albemarle, Va

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

W.H. BACON FUNERAL HOME

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

25c. REGISTRAR'S SIGNATURE

3447 14TH ST, N.W. WASHINGTON, DC

NOV 24 1987

Julia Deason

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

12555 N 12th

12555 N 12th  
12555 N 12th  
12555 N 12th

12555 N 12th

12555 N 12th

12555 N 12th

12555 N 12th

12555 N 12th

12555 N 12th

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked gr, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas Edward Cindric			2a. DATE OF DEATH MONTH DAY YEAR November 12, 1987		2b. HOUR 5:30 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1939	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) K Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GLB Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	12b. KIND OF BUSINESS OR INDUSTRY Dept. of Defence	
13a. STATE Md.		13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6114 Goodman Road 20707
14. FATHER'S NAME FIRST MIDDLE LAST John Cindric		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Krznaric			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) AirForce		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DEDUCTION) 1963-1966	17. INFORMANT ADDRESS Mary Catherine Cindric same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>POST MYOCARDIAL INFARCT + CARDIOMYOPATHY</u>					
19a. DATE OF OPERATION 11/10/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EMBOLEUSITIS, PANCREATITIS		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>85</u> to <u>Present</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Luis A. Casas</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS A. CASAS MD		22e. ADDRESS 8317 CHESTNUT RD - LAUREL MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/16/87	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION Laurel P.G. County Md.		
24. FUNERAL DIRECTOR NAME 7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20707		25a. DATE RECEIVED BY REGISTRAR NOV 16 1987 25b. REGISTRAR'S SIGNATURE			



072462 NOV 9 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VICTOR NMI CLUNET</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 13 - 87</b>			2b. HOUR <b>8:15P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 11 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS			
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Parkwood Hospital, Inc.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dist. Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>			
13a. STATE <b>MD.</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Newberg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Clunet</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Turner</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>075-09-8641</b>		17. INFORMANT ADDRESS <b>Ruth M. Clunet Box 85 Newburg, Md. 20664</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Hepatic Insufficiency, Venous</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>November 6, 19 87</b> to <b>November 13, 19 87</b> , that (I) (we) last saw the deceased alive on <b>November 13, 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>Michael Levine</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/14/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Levine</b>				22e. ADDRESS <b>7801 Old Branch Ave, #409, Clinton, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 14, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton PG Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lee Funeral Home Inc 6633 Old Alexander Ferry Rd. Clinton, Md. 20735</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1987</b>				25b. REGISTRAR'S SIGNATURE <b>Julia Friedman-Randee</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





073388 NOV 30 1987

FOR  
STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH33258  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Dean Conley</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>Nov 22 1987</i>			2b. HOUR <i>8 PM</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 6, 1905</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>82 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <i>Nov 22 1987</i>	2d. HOUR <i>8 PM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Minnesota</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD.</i>		
10. CITY OR TOWN OF DEATH <i>Laurel</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greensboro Beltsville Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Administrator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY <i>Pennsylvania Chester</i>			13c. CITY OR TOWN <i>Wayne</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>10 Drummer Lane</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Conley</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Josephine Dean</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT <i>Doris Conley (wife)</i>		ADDRESS <i>as above #13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>None</i>								
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>John P. Rogers</i>		TITLE (SPECIFY) <i>M.D.</i>		MEDICAL EXAMINER			DATE SIGNED <i>Nov 22 1987</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John P. Rogers</i>		ADDRESS						
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>Nov. 27, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>St. Paul, Minnesota</i>		
24. FUNERAL DIRECTOR NAME <i>Ives-Pearson Funeral Homes</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 27 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John P. Rogers</i>		
ADDRESS <i>Arlington, Va.</i>								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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NOV 21 1981

RECEIVED

073815 DEC

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LILLIAN M. COOK			2a. DATE OF DEATH MONTH DAY YEAR 11 18 87		2b. HOUR 11 30AM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 09 23 98	6. AGE (IN YEARS LAST BIRTHDAY) 89	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Capitol Hgts	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4217 Will St. 20743	
14. FATHER'S NAME FIRST MIDDLE LAST William H. DAVIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 326-40-7159		17. INFORMANT ADDRESS Virginia E. Holmes, 4217 Will St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxic Encephalopathy. DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OBS, Small Bowel Obstruction, s/p cva, Old Meningioma.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 85 Nov. 18 87 to Nov. 18 87, that (I) (we) last saw the deceased alive on Nov. 18 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22a. SIGNATURE Stuart Turkewitz		DEGREE		22b. DATE SIGNED 11/19/87	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Turkewitz		22d. ADDRESS 7500 Greenway Ctr. Dr. Greenbelt, Md. 20770		22e. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11-23-87	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY Suitland Prince Geo. Md.	
24. FUNERAL DIRECTOR NAME W.W. Chambers F.H. 577-11th St. SE Washington		25a. DATE REC'D BY REGISTRAR DEC 02 1987		25b. REGISTRAR'S SIGNATURE in [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

071396 NOV 10 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3260

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Viola Isabel Craver</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-3-87</b>		2b. HOUR <b>11:59<sup>AM</sup></b>						
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 13 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. UNDER 1 YEAR MONTHS DAYS <b>86</b>		7. UNDER 74 HRS HOURS MIN. <b>86</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD</b>					
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BELTSVILLE HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Typist (Ret)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Navy</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Fulton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS / ZIP CODE <b>11925 Queen Street 20759</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Lager</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mammie Wojackski</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE BRANCH) (IF YES, GIVE WAR & DATES) <b>n/a</b>		16b. SOCIAL SECURITY NO. <b>216-44-9268</b>		17. INFORMANT ADDRESS <b>Charles M. Craver same as 13c</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Vascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>321 Prince Georges St Laurel 20702</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>10-26</b> , 19 <b>87</b> , to <b>11-3</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William A. Warren</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-3-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm A. Warren</b>		22e. ADDRESS <b>321 Prince Georges St Laurel 20702</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/06/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Ch. Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fulton Howard Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel Md. 20707</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John E. ...</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that be death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY A. LAST CRONK.		2a. DATE OF DEATH MONTH DAY YEAR 11-2-87		2b. HOUR 505 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 17, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO-MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7900 Locust Lane 20744	
14. FATHER'S NAME FIRST Frank MIDDLE J. LAST VanDerWarker		15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE E. LAST Bibby		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 112-46-0583		17. INFORMANT ADDRESS 7900 Locust Lane Ft. Washington, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular D</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>7 years</u> <u>12 hr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>11/2</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE <u>Thomas L. Fielden</u>		DEGREE MA ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3 Nov 87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS FIELDSON</u>		22e. ADDRESS <u>BANDWING MD 20613</u> <u>BANDWING WACDOCK. MED CENTER</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/4/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR NOV 5 1987
25b. REGISTRAR'S SIGNATURE <u>Thomas L. Fielden</u>				

BP





073429 DEC 1 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jim Crowell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 21 87</b>			2b. HOUR <b>9:04p M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 4 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PG</b> MD.			
10. CITY OR TOWN OF DEATH <b>Md., Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Presidential Woods Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>629 Sheridan St. 20783</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fletcher Crowell, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-16-4394</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy M. Gray/620 Sheridan St. Hyattsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with metastasis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/20/87</b> to <b>11/21/87</b> , that (I) (we) last saw the deceased alive on <b>11/21/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Myron L. Lenkin</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>			22e. ADDRESS <b>2309 STOREFIELD RD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-28-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>John T. Rhines Co., 3015 12th St. N.E., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon patient permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified of same.

BP \_\_\_\_\_

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		UNK.#87-120								33203	
2. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. MONTH DAY YEAR	
LARRY W. CROWLEY								11-24 1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	Black	June 6 1953		34 YRS.		MONTHS DAYS HOURS MIN		MONTH DAY YEAR		11-24 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
Alabama		U.S.		WIDOWED		DIVORCED		Prince George's County, MD.		10:03 P.M.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's General Hospital				Unemployed		None			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
D.C.		-		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1390 Nicholson St. N.W.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Alonza		Rosa Lee Ware		418-74-1722		Regina Crowley		3901 Suitland Rd		1519	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		19-72 to 5-84		418-74-1722		Regina Crowley		3901 Suitland Rd		1519	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Gunshot Wound of Abdomen (Handgun)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		5:00 P.M. 11-24 1987		subject was shot		WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		STREET CITY OR TOWN COUNTY STATE		2700 Blk. Nicholson St., Hyattsville, Prince	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION		21h. LOCATION		21i. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		STREET CITY OR TOWN COUNTY STATE		STREET CITY OR TOWN COUNTY STATE		STREET CITY OR TOWN COUNTY STATE	
		parking lot		2700 Blk. Nicholson St., Hyattsville, Prince		2700 Blk. Nicholson St., Hyattsville, Prince		2700 Blk. Nicholson St., Hyattsville, Prince		2700 Blk. Nicholson St., Hyattsville, Prince	
22a. I certify that I took charge of the remains described above, held an										22b. I certify that I took charge of the remains described above, held an	
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										George's Co., Md.	
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED	
Ann M. Dixon, M.D.		Deputy Chief		11-25-87		11-25-87		11-25-87		11-25-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS	
Ann M. Dixon, M.D.		111 Penn St., Balto., Md. 21201		111 Penn St., Balto., Md. 21201		111 Penn St., Balto., Md. 21201		111 Penn St., Balto., Md. 21201		111 Penn St., Balto., Md. 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. LOCATION		23f. LOCATION	
Burial		12-5-87		Lincoln Hill Cemetery		Gadsden (E town) Alabama		Gadsden (E town) Alabama		Gadsden (E town) Alabama	
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
NAME		ADDRESS		NAME		ADDRESS		NAME		ADDRESS	
Robert G. Mason		1661 Good Hope Rd		Robert G. Mason		1661 Good Hope Rd		Robert G. Mason		1661 Good Hope Rd	

994417  
BP  
DHMH - 17  
(VR A15 ME (5))

REC-01 103350

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DEC 01 1988

74528 DEC-98

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Elizabeth

K.

Cumbo

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE

8. MONTH

9. DAY

10. YEAR

11. HOUR

Female

Black

Oct. 5, 1902

85

YRS.

MONTHS

DAYS

HOURS

MIN.

11/30

19

87

10:55

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Virginia

United States

Prince George's County

MD.

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Brentwood

3708 Allison Street

Clerk

U.S. Government

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

Maryland

Prince George's

Brentwood

YES ☐NO ☐

3708 Allison Street

14. FATHER'S NAME

MIDDLE

LAST

John

Kave

15. MOTHER'S MAIDEN NAME

MIDDLE

LAST

Martha

Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

No

577-18-2078

Andrew W. Lowe/1236 45th Pl., S.E. DC

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic carcinoma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

(b)

carcinoma of the breast.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

None

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

None

YES ☐NO ☒

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

P.M.

19

None

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED

11/30/87

EXAMINER'S NAME (TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

1919 Seminary Road  
Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

Burial

December 4,

Lincoln Memorial Cemetery Suitland, Maryland

24. FUNERAL DIRECTOR NAME

McGuire Funeral Service

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

7400 Georgia Ave.,  
N.W. DC

DEC - 7 1987

John S. Rogers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. CIVILIAN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

1

careless of the present.

• • • • •

073506 DEC 1 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alice E. CURLES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/26/87</b>		2b. HOUR / AM PM <b>4:40 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 22, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.			
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hospital Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Temple Hills</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4503 Weldon Dr. 20748</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Friebe</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara These</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-07-8322</b>		17. INFORMANT ADDRESS <b>Beverly F. Wilson 4503 Weldon Dr. Temple Hills, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro pulmonary Anoxia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain Ischemia, Cerebral Phle-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Stroke</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-09-1987</b> to <b>11-26-87</b> , that (I) (we) last saw the deceased alive on <b>11-25-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Abulhasan Uansari, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-26-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABULHASAN UANSARI, MD</b>		22e. ADDRESS <b>8922 Woodward Rd #101 Clinton, Md. 20535</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		6160 Oxon Hill Rd. ADDRESS <b>Oxon Hill, Md.</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Randall</b>			

MEDICAL CERTIFICATION

29

BP

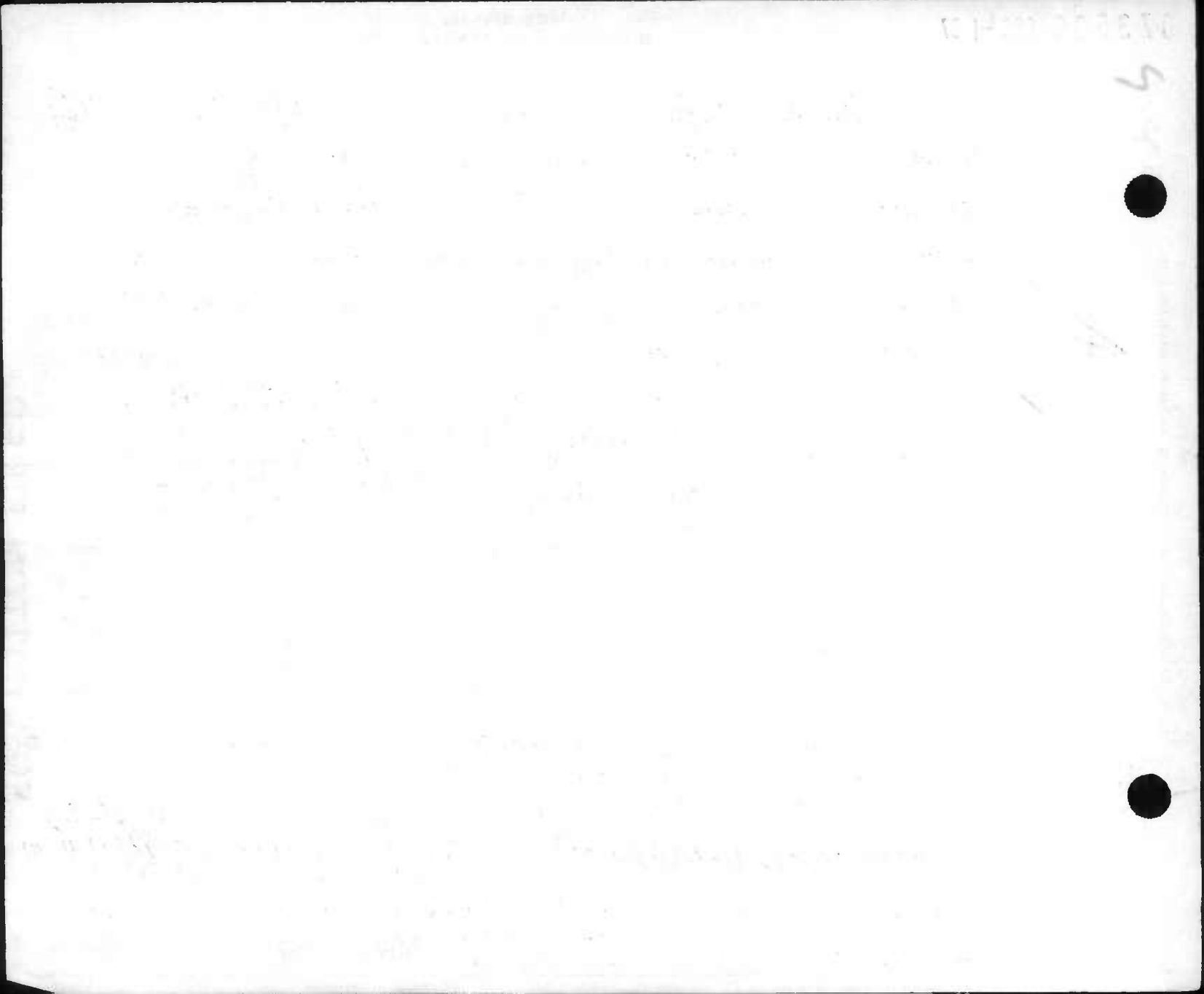
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, place the certificate in the envelope and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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4



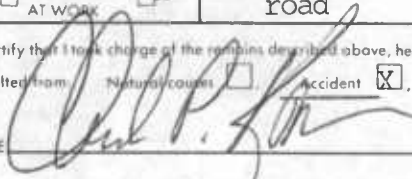


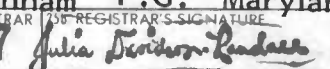
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Richard Lionel Curtin, Jr.			2a. DATE KNOWN OF DEATH ESTIMATED 11-17-87		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 22, 1949	6. AGE (IN YEARS) (LAST BIRTHDAY) 38 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Bowie	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Lionel Curtin, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Dowell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes-Army Vietnam		16b. SOCIAL SECURITY NO. 214-52-6885		17. INFORMANT 12414 Chalford Lane Susan Curtin (Wife) Bowie, Maryland 20715	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8162 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY 10:55PM 11-16-87 P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of motorcycle lost control and ejected
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road	21f. LOCATION STREET CITY OR TOWN COUNTY Route 50, Glenarden, Prince George's Co., MD
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE 		TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 11-17-87
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/20/87	23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25. DATE REC'D. BY REGISTRAR NOV 24 1987 25. REGISTRAR'S SIGNATURE 	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
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(VR A15 ME (5))

NOV 24 1981

FOR COTTON LINES

WATERWAY

072603 NOV 20 1987

Item 18a, 22a, G634 12-30-87 dw

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33267

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Pamela		L.		Cypress				10-30-1987				10-30		1987				12:55 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	Black	Jan. 15, 1964		23 YRS.						10-30-1987		10-30		1987				P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
D.C.		U.S.A.		WIDOWED		DIVORCED		Prince George's County										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY													
Riverdale		Eugene Leland Memorial Hospital		Student		School													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		P.G.		Temple Hills		YES		3424 23rd Parkway											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
William		Alicetine		Cypress		McDaniel													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		Unknown		Alicetine Cypress-Same as # 13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Sickle cell disease																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION																			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																			
20. AUTOPSY?																			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																			
21b. TIME OF INJURY																			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
21d. INJURY OCCURRED																			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																			
21f. LOCATION																			
21g. CITY OR TOWN																			
21h. COUNTY																			
21i. STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE																			
TITLE (SPECIFY)																			
M.D. Deputy Chief																			
MEDICAL EXAMINER																			
DATE SIGNED																			
10-31-87																			
EXAMINER'S NAME																			
(TYPE OR PRINT)																			
Ann M. Dixon, M.D.																			
ADDRESS																			
111 Penn Street, Baltimore, MD 21201																			
23a. BURIAL, CREMATION, REMOVAL																			
23b. DATE																			
23c. NAME OF CEMETERY OR CREMATORY																			
23d. LOCATION																			
CITY OR TOWN																			
COUNTY																			
STATE																			
24. FUNERAL DIRECTOR																			
NAME																			
ADDRESS																			
H. S. WASHINGTON & SONS 4925 BURNING WOOD AVE N.E.																			
25a. DATE REC'D. BY REGISTRAR																			
25b. REGISTRAR'S SIGNATURE																			
NOV 19 1987																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 2, AND TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-101. THIS PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP 877

DHMH - 17  
(VR A15 ME (5))

Encls. 3 (enc. 1, 2, 3)

100-100000

100-100000

100-100000

100-100000

100-100000

(2)

100-100000

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR					
Zachary Daggett						11/ 22/1987						M					
3. RACE			4. AGE (IN YEARS) (LAST BIRTHDAY)			5. DATE OF BIRTH MONTH DAY YEAR			6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7. DATE PRONOUNCED DEAD			MONTH DAY YEAR		
Male			Black			1 25 58			29 YRS.			11/22/ 1987			2:22 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Georgia			U.S.A.						Prince George's County, MD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Cheverly			Prince George's General Hospital			Laborer			Private								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Prince Georges			Landover						6915 Kent Town Drive			20785		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Ruben Daggett			Dorothy Walker														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT											
No			217-72-2604			Dorothy Daggett Landover, Md. 20785											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of Back (unspecified)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR 1:29 P.M. 11/22/ 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on street			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2400 Virginia Ave., Landover, Pr. Geo., Md.											
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE			TITLE (SPECIFY)			MEDICAL EXAMINER			DATE SIGNED								
Dennis F. Smyth			Assistant						11/23/87								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS														
Dennis F. Smyth, M.D.			111 Penn St., Balto., Md. 21201														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial			11-28-87			Maryland National			Laurel P.G. Maryland								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
J. B. Jenkins			7474 Landover Road Landover, Md. 20785			NOV 25 1987			Dennis F. Smyth								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAYS ARE NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. IN PENALTY IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

013300 RM1511

013300 RM1511



013300 RM1511

072016 Nov 19-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louise Miles Darneille</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11/9/87</i>		2b. HOUR <i>11:05 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 25 1902</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Takoma Park Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>85</i>		
10. CITY OR TOWN OF DEATH <i>CLINTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Maryland Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES MD</i>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Buyer Palais Royal Dept St</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>ore</i>				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr George</i>		13c. CITY OR TOWN <i>Forestville</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Miles</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Linda Murphy</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-12-5494</i>		17. INFORMANT ADDRESS <i>3021 Conococheague Ln GreenCastle, Penna</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CHRONIC OBSTRUCTIVE PUL DIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>20 yrs</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>20 yrs</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1 Oct</i> , 19 <i>86</i> , to <i>10 Nov</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>9 Nov</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>William J. Letzger, M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/10/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William J. Letzger</i>		22e. ADDRESS <i>3611 Brandel Ave 1-emele Hill MD 20748</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12 Nov 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood PG MD</i>						
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>		ADDRESS <i>Suitland, Md.</i>		25a. DATE RECD. BY REGISTRAR <i>NOV 10 1987</i>		
				25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1801/2/3/4/5/6/7/8/9/10/11/12

Case No. 12345

Page 1

In the County of ... State of ...

Plaintiff vs. Defendant

Comes now the Plaintiff and alleges that

the Defendant has wrongfully

infringed upon the Plaintiff's

rights in the following manner:

1. The Defendant has

used the Plaintiff's

name and likeness

for commercial purposes

without the Plaintiff's

consent or permission.

2. The Defendant has

caused damage to the

Plaintiff's reputation

and has caused the

Plaintiff to suffer



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 7 3 3 2 7 0

073484 DEC-18

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Maurice Edward DAROIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 26, 1987</b>		2b. HOUR <b>6:02A M</b>	
3. SEX <b>Male.</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 18, 1919.</b>		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Hampshire.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>68</b>		
10. CITY OR TOWN OF DEATH <b>Lanham.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dr's Hospital Lanham Md.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fed. Govt. Navy Yard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>				
13a. STATE <b>Maryland.</b>			13b. COUNTY <b>Prine Geo.</b>		13c. CITY OR TOWN <b>Mt. Rainier.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Darois.</b>			15. MOTHER'S MAIDEN NAME LAST <b>Not Available</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>U. S. Navy.</b>		16b. SOCIAL SECURITY NO. <b>010-12-7631</b>		17. INFORMANT ADDRESS <b>Marjorie A. Strippy. (13)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EMPHYSEMA PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE RENAL FAILURE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>STROKE WITH RT. HEMIPLEGIA.</b>						
19a. DATE OF OPERATION <b>10/5/87 + 10/6/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FAIR.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 29, 1987</b> to <b>Nov. 26, 1987</b> , that (I) (we) last saw the deceased alive on <b>Nov. 25, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>YK Kwon MD</b>				22c. DATE SIGNED <b>11/26/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>YK-KWON H. Yoon MD</b>				22e. ADDRESS <b>7307 Beltsmore Ave. #111 College Park, Md. 20740</b>		
23a. BURIAL, CREMATION, REMOVAL <b>Burial.</b>		23b. DATE <b>Dec-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln. Brentwood P. Geo Co, Md.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. C.D. BY REGISTRAR <b>NOV 30 1987</b>				
24. FUNERAL DIRECTOR <b>Takoma Funeral Home Inc.</b> <b>254 Carroll St. N. W.</b>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33271

1- STATE  
REGISTRAR

2. DECEASED NAME  
(IF PRINT)

FIRST

MIDDLE

LAST

Henry Ernest Davis

2a. DATE KNOWN OF DEATH ESTI- MATED  
2b. DATE KNOWN OF DEATH ESTI- MATED  
2c. DATE KNOWN OF DEATH ESTI- MATED  
2d. DATE KNOWN OF DEATH ESTI- MATED  
2e. DATE KNOWN OF DEATH ESTI- MATED  
2f. DATE KNOWN OF DEATH ESTI- MATED  
2g. DATE KNOWN OF DEATH ESTI- MATED  
2h. DATE KNOWN OF DEATH ESTI- MATED  
2i. DATE KNOWN OF DEATH ESTI- MATED  
2j. DATE KNOWN OF DEATH ESTI- MATED  
2k. DATE KNOWN OF DEATH ESTI- MATED  
2l. DATE KNOWN OF DEATH ESTI- MATED  
2m. DATE KNOWN OF DEATH ESTI- MATED  
2n. DATE KNOWN OF DEATH ESTI- MATED  
2o. DATE KNOWN OF DEATH ESTI- MATED  
2p. DATE KNOWN OF DEATH ESTI- MATED  
2q. DATE KNOWN OF DEATH ESTI- MATED  
2r. DATE KNOWN OF DEATH ESTI- MATED  
2s. DATE KNOWN OF DEATH ESTI- MATED  
2t. DATE KNOWN OF DEATH ESTI- MATED  
2u. DATE KNOWN OF DEATH ESTI- MATED  
2v. DATE KNOWN OF DEATH ESTI- MATED  
2w. DATE KNOWN OF DEATH ESTI- MATED  
2x. DATE KNOWN OF DEATH ESTI- MATED  
2y. DATE KNOWN OF DEATH ESTI- MATED  
2z. DATE KNOWN OF DEATH ESTI- MATED

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

2d. DATE PRONOUNCED DEAD

Male

Caucasian

March 21 27

60 YRS.

MONTHS DAYS HOURS MIN

Nov. 2 1987

Nov. 2 1987

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?  
United States

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH  
Prince Georges MD.

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Langley Park

1520 Kansas Ave Apt 103

Exterminator

Extermination

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS

14. FATHER'S NAME  
FIRST MIDDLE LAST  
Henry Ernest Davis

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Esther M. Brown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
Yes W.W. II

16b. SOCIAL SECURITY NO  
577 32 6557

17. INFORMANT  
Patricia A. Gollan

ADDRESS 20817

9015 Kirkdale Road

Bethesda, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Acute Myocardial Inf.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

None

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Dep MEDICAL EXAMINER

DATE SIGNED Nov. 2 1987

EXAMINER'S NAME (TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS 1919 Seminary Rd. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
November 05, 1987

23c. NAME OF CEMETERY OR CREMATORY  
Cedar Hill Cemetery

23d. LOCATION  
CITY OR TOWN COUNTY STATE  
Suitland Maryland

24. FUNERAL DIRECTOR  
Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Ave. Bethesda, Maryland

25a. DATE RECD. BY REGISTRAR  
NOV 09 1987

25b. REGISTRAR SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PENDING" TO BE KEPT IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

021305 NOV 10 85



NOV 10 85

073899 DEC-3-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE KNOWN OF DEATH		HOUR	
Ralph Lawrence Davis		11-24-87		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	Cauc.	07 19 11	76 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.	WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Prince George's	MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Suitland	4400 West Summer Rd.	Union Painter	Painting		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Prince Georges	Suitland	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4400 West Summer Rd.	20746
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Unknown	Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
No	N/A	Lance Davis	1015 Bannister Circle Waldorf, Md. 20601		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
<i>Augusto P. Rodriguez</i>		M.D. Deputy		11-26-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct. Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. REGISTRAR'S SIGNATURE	
Cremation	11/28/87	Lee's Crematory	Clinton Prince George's Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home, Inc.		DEC 02 1987			
6633 Old Alexander Ferry Rd Clinton, Md 20735					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGE 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 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799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33274

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
James Earl Dawson						11-16			1987			M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR				
Male	White	8-4-33	54	MONTHS DAYS		HOURS MIN.		11-16			1987				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			
Frostburg, Maryland			U.S.A.			WIDOWED			DIVORCED			Prince George's			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY						
Camp Springs			6537 Beechwood Drive			Self Employed Cab Driver			Transportation						
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?						13e. STREET ADDRESS	
Maryland				P. G.		Camp Springs		YES		NO		X		6537 Beechwood Dr. 20748	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			
James A. Dawson			Mary V. Layman			Yes			1953			208-24-8316			
												Patricia L. Dawson Same as 13 A-E			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		
<u>Chronic obstructive pulmonary disease</u>		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED	
Augusto P. Rodriguez	M.D. Deputy	71-16-87	
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
Augusto P. Rodriguez, M.D.	5009 Rayburn Ct, Temple Hills, MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN) COUNTY STATE
Burial	11/19/87	Ft. Lincoln Cemetery	Bladensburg Prince Geo. Md.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Lee Funeral Home, INC.		NOV 18 1987	
25b. REGISTRAR'S SIGNATURE			
6633 Old Alexander Ferry Rd Clinton, Md 20735		Julia Fisher-Rodriguez	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN ITEM 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

DHMH - 17

(VR A15 ME 6633

12425 JUN 1901

RECEIVED  
JUN 19 1901

June 19 1901  
Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 14th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours,  
J. H. [Name]

Very truly,  
J. H. [Name]

Enclosed for you are the documents referred to in my letter of the 14th inst.

I am, Sir, very respectfully,  
Yours,  
J. H. [Name]

Very truly,  
J. H. [Name]

11-1-11  
NOV 18 1901

068817 OCT

Items 18a, 20, 21a, b, c, d, e, f, 22a, G633 dw STATE OF MARYLAND  
 FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE /  
 1- STATE 11-13-87 per med exam  
 REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 10/ 3/ 1987 2b. HOUR 5:00 PM

DECEASED NAME (TYPE OR PRINT) Juanita C. Diggs FIRST MIDDLE LAST

3. SEX FEMALE 4. RACE BLACK 5. DATE OF BIRTH MONTH DAY YEAR 8 18 1908 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 7c. DATE PRONOUNCED DEAD 10/ 3/ 1987 24. HOUR 5:00 PM

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD

10. CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE MARYLAND 13b. COUNTY A.A. 13c. CITY OR TOWN ANNAPOLIS 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 13e. STREET ADDRESS MADISON Street 21401

14. FATHER'S NAME FIRST MIDDLE LAST MOSES BROWN 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA WILLIAMS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 213-36-3835 17. INFORMANT ADDRESS 210 Pindell Ave., Annapolis, Md. 21401 EVANGELINE PINDELL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injuries with complications DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:10 P.M. 8-20 1987 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject beaten

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 909 Madison Street Annapolis, Anne Arundel, MD.

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 10/4/87

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 10-2-1987 23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland

24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. 25a. DATE REC'D BY REGISTRAR OCT 15 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

073188

NOV 27 1987

1 - STATE REGISTRAR

2a DECEASED NAME (TYPE OR PRINT) <b>Myrtle Eleanor Dodge</b>			2b DATE OF DEATH MONTH DAY YEAR <b>November 18, 1987</b>		2c HOUR <b>11:00 A</b>	
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 23, 1891</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>		10 CITY OR TOWN OF DEATH <b>Mt. Rainier</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3220 Chillum Road, #201</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a STATE <b>Maryland</b>		13b COUNTY <b>P.G.</b>		13c CITY OR TOWN <b>Mt. Rainier</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Harvey</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Bertha Kendrick</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>577-07-3930</b>		17 INFORMANT ADDRESS <b>Bertha Davis (Daughter) Hyattsville, Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20.782</b> Months <b>Years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (his hospital) attended the deceased from <b>July</b> , 19 <b>83</b> , to <b>November</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>November 9, 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>David C. Lanier, MD</b>				22c. DATE SIGNED <b>11/19/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. David C. Lanier, M.D.</b>				22e. ADDRESS <b>3001 Bladensburg Rd. NE Washington, D.C.</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>11/21/87</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery Suitland P.G. Maryland</b>		
24 FUNERAL DIRECTOR <b>Francis Gasch's Funeral Home, P.A.</b> <b>4739 Baltimore Avenue Hyattsville, Md. 20781</b>				25a DATE REC'D BY REGISTRAR <b>NOV 25 1987</b>		
25b REGISTRAR'S SIGNATURE <i>Julia Benson</i>						

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Loretta Frances DOERING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 2 1987</b>		2b. HOUR P <b>4:00 M</b>		
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 31 1902</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>85</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>	
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greenbelt Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Exec. Secretary</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Seabrook</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Julius LaBroski</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma M. DuFore</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO <b>386-26-6262</b>		17. INFORMANT ADDRESS <b>Lorna Monit 734 Darwin Westland, Michigan 48185</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest, secondary to arrhythmia</b> <b>Sudden</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> <b>Unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Old stroke</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5 March 1976</b> to <b>2 November 1987</b> that (I) (we) lost saw the deceased alive on <b>2 November 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Carl J. Houmann</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2 Nov., 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carl J. Houmann, M. D.</b>				22e. ADDRESS <b>4404 Queensbury Rd., Riverdale, MD 20737</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/10/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodmere Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Detroit, Michigan</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Rendon/Hale Lanham Fun'l Home</b> <b>9013 Annapolis Rd. Lanham, Md. 20706</b>				DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>		REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

33278

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MARY	MIDDLE Florence	LAST DOTSON	MONTH 11	DAY 7	YEAR 87	7.20am		
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH 12 DAY 25 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2669 Rokshead Place 20601				
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Sewell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmyra Pinkney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 220 34 8665		17. INFORMANT ADDRESS Warren Dotson SAA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>old CVA - Diabetes - ASHD - HT - Renal Disease</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK A) WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>10/21</i> 19 <i>87</i> to <i>11/7</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>11/6/87</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Robert M. Adams</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/7/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert M. Adams</i>				22e. ADDRESS <i>4235 26th Ave Md-20745</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		12 Nov 87		Christ Church Cem		Baden, P.G.Co., MD		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Martell Adams, Aquasco Md 20608</i>				25a. DATE REC'D. BY REGISTRAR NOV 13 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Decker-Rudolph</i>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

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*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers and file in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WADE L. DOWTIN			2a. DATE OF DEATH MONTH DAY YEAR 11-24-87		2b. HOUR 3 21A M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR February 5, 1950		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver, Retd.	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Landover	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1200 Fiji Avenue 20785
14. FATHER'S NAME FIRST MIDDLE LAST Edward Lee Downtin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Dent			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-66-4971		17. INFORMANT ADDRESS Sarah Downtin (wife) same as item #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>AIDS &amp; Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> , 19 <u>87</u> , to <u>11/24</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>T. Mander</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>11/24/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>T. MANDER</u>		22e. ADDRESS <u>Pr. Geo. Hosp. CNTR.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-28-87	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.	
24. FUNERAL DIRECTOR Vann & Williams, 4804 Ga. Ave., N.W., Wash., D.C.		25a. DATE REC'D. BY REGISTRAR DEC 02 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

BP



072444 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33280

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Grotola</i>		MIDDLE <i>Drew</i>		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <i>11-10-87</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <i>Maryland</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>District Hgts</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Hypertensive atherosclerotic cardiovascular</i>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22b. DATE (SPECIFY)	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION CITY OR TOWN COUNTY STATE		22e. DATE REC'D. BY REGISTRAR (SEE REG. NO. SIGNATURE)		22f. NAME OF FUNERAL DIRECTOR		22g. ADDRESS		22h. DATE (SPECIFY)	
22i. BURIAL, CREMATION, REMOVAL		22j. DATE		22k. NAME OF CEMETERY OR CREMATORY		22l. LOCATION CITY OR TOWN COUNTY STATE		22m. DATE REC'D. BY REGISTRAR (SEE REG. NO. SIGNATURE)		22n. NAME OF FUNERAL DIRECTOR	
22o. ADDRESS		22p. DATE		22q. NAME OF CEMETERY OR CREMATORY		22r. LOCATION CITY OR TOWN COUNTY STATE		22s. DATE REC'D. BY REGISTRAR (SEE REG. NO. SIGNATURE)		22t. NAME OF FUNERAL DIRECTOR	

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

ACTUAL SIGNATURE *Augusto P. Rodriguez* TITLE (SPECIFY) *Deputy* MEDICAL EXAMINER DATE SIGNED *10 NOV 87*  
EXAMINER'S NAME (TYPE OR PRINT) *Augusto P. Rodriguez MD* ADDRESS *5009 Bayview Ct, Sp. Pk, Va*  
22a. BURIAL, CREMATION, REMOVAL *Burial* 22b. DATE *Nov. 13, 1987* 22c. NAME OF CEMETERY OR CREMATORY *Tod Homestead Memorial Cemetery* 22d. LOCATION *Youngstown*  
22e. DATE REC'D. BY REGISTRAR (SEE REG. NO. SIGNATURE) *NOV 18 1987* 22f. NAME OF FUNERAL DIRECTOR *Stewart Funeral Home* 22g. ADDRESS *4001 Benning Road, N.E.*

11-10-1917  
11-10-1917

RECEIVED  
11-10-1917

Handwritten notes and signatures, including a large circular stamp.

Handwritten notes and signatures at the bottom of the page.

073288 NOV 27 1987

DIVISION OF VITAL RECORDS, 301 W. WESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST OSCAR	MIDDLE J.	LAST DUNMORE	2a. DATE OF DEATH MONTH DAY YEAR NOV. 15, 1987		2b. HOUR 3:30 A.M.			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAR. 17, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DIST. COLUMBIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.				
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 930 RAY ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MIL. PERS. SPEC.		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY PR. GEORGE		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR J. DUNMORE, SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HESTER ROYSTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS ORENE DUNMORE, 930 Ray Road, HYATTSVILLE, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pulmonary Metastasis from</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cervical Prostate Stone Dr.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 months</u> <u>2 years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/27/54</u> , 19 <u>54</u> , to <u>Present</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/21/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>George W. Jones, MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/14/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George W. Jones, MD		22e. ADDRESS 2139 G. Ave NW suite 4A								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE NOV. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION LANDOVER, MD. COUNTY STATE				
24. FUNERAL DIRECTOR NAME <u>William Greene</u>		GREENE FUNERAL HOME, INC. 814 ARLINGTON STREET ALEXANDRIA, VIRGINIA 22314				25. DATE REC'D. BY REGISTRAR NOV 20 1987		26. REGISTRAR'S SIGNATURE <u>William Greene</u>		

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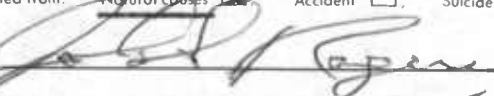
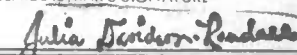
Item 1, Film G634 12-1-87

FOR STATE REGISTRAR per funeral home

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33282

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Annabelle Mary M. Dyer</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10/17 19 87</b>			2b. HOUR <b>9:25 P.</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jul. 10, 1895</b>	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>92 YRS.</b>	7. DATE OF BIRTH MONTH DAY YEAR <b>10/17 19 87</b>	7c. DATE PRONOUNCED DEAD <b>10/17 19 87</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7401 Glenside Drive</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. US Bureau of Engraving</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7401 Glenside Drive</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles -- MacNamee</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sara --- MacNamee</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-52-3887</b>		17. INFORMANT ADDRESS <b>MRS. LORETTA MOON-Clarksville, Md. 21029</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>								
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER <b>1919 Seminary Road</b>		DATE SIGNED <b>10/17/87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>		ADDRESS <b>Silver Spring, Montgomery County, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>OCT. 20, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD, MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>HYSONG CO., INC.-1300 N ST., NW WASH., DC</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1987</b>		25b. REGISTRAR'S SIGNATURE 		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

Annabelle

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Prince George's County

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THELMA H. EARLY			2a. DATE OF DEATH MONTH DAY YEAR 11 27 87			2b. HOUR 4:35A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 05 17		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Pr George		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hephburn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Hendrick			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-10-4335			17. INFORMANT Charles C Early			ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Interlobular pneumonitis</u>									
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>N/A</u> P.M. <u>N/A</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>N/A</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> <u>N/A</u>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) <u>N/A</u>		21f. LOCATION STREET <u>N/A</u>		CITY OR TOWN <u>N/A</u>		COUNTY <u>N/A</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> 19 <u>87</u> to <u>11/27</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Gerardo M. Gacard</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GERARDO M. GACARD</u>				22e. ADDRESS <u>6492 Landover Rd. Landover MD</u>					
23a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		23b. DATE <u>30Nov1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Suitland</u>		COUNTY <u>PG</u>	
24. FUNERAL DIRECTOR NAME <u>Robert E Wilhelm</u>		ADDRESS <u>Suitland, Md</u>		25. DATE REC'D BY REGISTRAR <u>DEC 01 1987</u>		25. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

053801-01

THE  
UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
HEADQUARTERS  
WASHINGTON, D.C.

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to poor scan quality. It appears to be a memorandum detailing military operations or administrative matters.]

[Illegible text continues...]

DEC 1967

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Helen

Grace

Edelen

2a. DATE KNOWN OF DEATH ☐ MONTH ☐ DAY ☐ YEAR ☒ 11-16 19 87 2b. HOUR M

3. SEX  
Female

4. RACE  
White

5. DATE OF BIRTH  
MONTH DAY YEAR  
6-21-11

6. AGE (IN YEARS)  
(LAST BIRTHDAY)  
76 YRS.

IF UNDER 1 YR  
MONTHS DAYS

IF UNDER 24 HRS.  
HOURS MIN.

7c. DATE PRONOUNCED DEAD ☐ MONTH ☐ DAY ☐ YEAR ☒ 11-17 19 87 7d. HOUR M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Prince Georges MD

10. CITY OR TOWN OF DEATH  
Marlow Heights

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
3940 Bexley Place, Apt 303

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Saleslady

12b. KIND OF BUSINESS OR INDUSTRY  
Retail Store

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. COUNTY  
Pr. Georges

13c. CITY OR TOWN  
Marlow Heights

13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS  
3940 Bexley Place, #303 20748

14. FATHER'S NAME  
FIRST MIDDLE LAST  
John R. Edelen

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Ruby F. Bonell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
No

16b. SOCIAL SECURITY NO.  
578-12-4609

17. INFORMANT  
ADDRESS  
Karen W. Amorose 3101 Henry Ave. Temple Hills, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

*Hypertensive cerebral vascular disease*

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(a) DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?  
YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
*Augusto P. Rodriguez*

TITLE (SPECIFY)  
Deputy MEDICAL EXAMINER DATE SIGNED 11-17-87

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct, Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
11-21-87

23c. NAME OF CEMETERY OR CREMATORY  
Washington Nat'l. Cem.

23d. LOCATION  
CITY OR TOWN COUNTY STATE  
Suitland P.G. Md.

24. FUNERAL DIRECTOR  
NAME ADDRESS  
G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.

25a. DATE REC'D. BY REGISTRAR  
NOV 19 1987 25b. REGISTRAR'S SIGNATURE  
*Julia Benson-Rodriguez*

DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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VON 1811

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1703 NOV 13 87STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
Steven Michael Edwards		11 9 19 87		1:40	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. CITIZEN OF WHAT COUNTRY?	8. MARRIED
Male	Caucasian	Aug 30, 1968	19 YRS.	U.S.A.	NEVER MARRIED XX
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION
Cheverly Maryland	Temple Hills		4107 Henson Lane		Carpet Installer
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Maryland		P. G.	Morningside	6612 Pine Grove Drive 20746	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Stanley R. Edwards		Lois Sharon Newman		No	
17. INFORMANT		18. CAUSE OF DEATH		19. SOCIAL SECURITY NO.	
Stanley R. Edwards		Gunshot wound of head (handgun)		212-98-1464	
20. DATE OF OPERATION		21. TIME OF INJURY		22. HOW INJURY OCCURRED	
19 87		10 + P.M. 11 8 19 87		Subject shot	
23. EXTERNAL CAUSE WAS		24. PLACE OF INJURY		25. LOCATION	
UNDERLYING CAUSE OF DEATH		house		4107 Henson Lane, Temple Hills, P.G. Co, MD.	
26. I certify that I have held an		27. Autopsy		28. Inspection	
death resulted from		X		Inquiry	
Natural causes		Suicide		Undetermined manner	
29. ACTUAL SIGNATURE		30. TITLE (SPECIFY)		31. DATE SIGNED	
Charles P. Kokes, M.D.		Assistant		11/9/87	
32. EXAMINER'S NAME		33. ADDRESS		34. BALTIMORE CITY OR COUNTY OF DEATH	
Charles P. Kokes, M.D.		111 Penn St.		Prince George's County MD	
35. BURIAL, CREMATION, REMOVAL		36. DATE		37. NAME OF CEMETERY OR CREMATORY	
Burial		11-12-87		Resurrection Cemetery	
38. FUNERAL DIRECTOR		39. DATE REC'D. BY REGISTRAR		40. REGISTRAR'S SIGNATURE	
Lee Funeral Home, Inc.		NOV 12 1987		Julia Davidson-Randall	
6633 Old Alexander Ferry Rd Clinton, Md 20735					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

GENERAL NOTE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Ellen Virginia Sweeney Ewart		Female		Caucasian	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
May 9, 1914		73		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.		PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Clinton		SOUTHERN MARYLAND HOSPITAL		Dental Assis.	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STREET ADDRESS / ZIP CODE	
Dental		13a. STATE		1125A Heritage Pl. 20601	
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Ralph Emerson Sweeney		Frances Ann Taylor		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF	
577-03-8655		Dorothy S. Patterson Same as 13 A-E		(b) DUE TO, OR AS A CONSEQUENCE OF	
				(c) DUE TO, OR AS A CONSEQUENCE OF	
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (the hospital) attended the deceased from 11/18/87, to 11/23/87, that (I) last saw the deceased alive on 11/22/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE DEGREE 1MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 11/23/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Phillip Wisotsky M.D.		22e. ADDRESS Oxon Hill Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/30/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland		24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE	
old Alexander Ferry Rd Clinton, Md 20735		NOV 25 1987		Julia Davidson-Randall	

47  
86  
35  
080  
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 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886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0132117 035670

1. General

2. Specific

3. Conclusion

4. Remarks

5. Signature

6. Date

7. Initials

8. Comments

9. Notes

10. Other

11. Final

12. Check

13. Done

14. OK

15. Good

16. Very

17. Best

18. Excellent

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (PRINT) <b>SUSAN B. FAMIGLIETTI</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 20th 1987</b>		2b. HOUR <b>1:15 A.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 12 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD	
10. CITY OR TOWN OF DEATH <b>Calverton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13018 Belvue St.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Adm. Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>I.R.S.</b>
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Calverton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>same as #11</b> <b>20705</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul Bonelli</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antoniette Russo</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>167-20-4879A</b>		17. INFORMANT ADDRESS <b>Adrienne McGeehan same as #11</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Aspiration pneumonia &amp; sepsis</b> (c) <b>Large decubitus ulcer</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>Alzheimers type of dementia - Obstructive jaundice</b>					
19a. DATE OF OPERATION <b>10-16-87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>choledocolithiasis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>6-20-1985</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Nov-18-87</b>	
22a. I certify that (I) (this hospital attended the deceased from <b>10-22-87</b> to <b>Nov-18-87</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b. SIGNATURE <b>R. A. Matheus</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>NOV-20-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rafael A. Matheus, M.D.</b>		22e. ADDRESS <b>13018 Georgia Avenue. Wheaton, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/23/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Silver Spring Mont. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 23 1987</b>			
24. FUNERAL DIRECTOR <b>Donald V. Borgwardt funeral Home</b>		25a. REGISTRAR'S SIGNATURE <b>11/23/87</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 20 1987

SUSAN E. PAROLLETTI

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6 12 1901



Cardio-respiratory arrest  
Aspiration pneumonia & sepsis  
Large decubitus ulcer

Alzheimer's type of dementia - Destructive fundal

x

choledocholithiasis

10-16-87

Nov-18-87

8-30-1985

10-22-87

NOV-20-87

15015 Georgia Avenue, Wheaton, MD

Robert A. Mathews, M.D.

071808 NOV 16 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FAY MYRTLE L</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 8, 87</b>			2b. HOUR <b>9<sup>30</sup> A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 9 93</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>94</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Zealand</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL MANOR</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Life Insur.</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>13131 12th Street/20715</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Lambert</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann Galloway Shegoque</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>140-03-6957</b>		17. INFORMANT <b>John F. Fay, Bowie, Maryland 20715</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Heart Failure**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**4 days**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**Coronary Artery Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**10 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>79</b> , to <b>NOV 8</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>NOV 8</b> , 19 <b>87</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above (or we) (did) (do not) view the body after death.							
22b. SIGNATURE <b>James J. Foster</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/9/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James J. Foster</b>				22e. ADDRESS <b>916 19th N.W. WASH DC</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 11, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brownwood P.G. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>				25a. DATED AND SIGNED BY REGISTRAR'S SIGNATURE <b>NOV 13 1987</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NOV 13 1981  
NOV 13 1981

1- STATE per funeral home  
REGISTRAR1 DECEASED NAME FIRST MIDDLE LAST  
(TYPE OR PRINT) PEARLENE M. FENTRESS2a DATE OF DEATH MONTH DAY YEAR 2b HOUR  
Nov 13, 87 9 PM3 SEX Female 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR  
May 17 1922 6 AGE (IN YEARS LAST BIRTHDAY) 65  
IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky 7b CITIZEN OF WHAT COUNTRY? USA  
8 MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.10 CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital 12a USUAL OCCUPATION (IF NOT WORKING, GIVE WORKING LIFE) Homemaker 12b KIND OF BUSINESS OR INDUSTRY13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a STATE Maryland 13b COUNTY Pr Geo 13c CITY OR TOWN Camp Spring 13d INSIDE CITY LIMITS? YES ☐ NO ☐ 13e STREET ADDRESS / ZIP CODE 6516 Allentown Road 20748

14 FATHER'S NAME FIRST MIDDLE LAST Arthur Carr 15. MOTHER'S MAIDEN NAME MIDDLE LAST Etta Holder

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b SOCIAL SECURITY NO. 400 30 5311 17 INFORMANT ADDRESS  
E. Gene Jordan 5008 Meadowbrook Drive Silver Hill, Maryland18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Myocardial Infarction 6 hours  
DUE TO, OR AS A CONSEQUENCE OF (b) Post-operative Thoracotomy 3 days  
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Lung, Right upper lobePART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  
Chronic Obstructive Pulmonary Disease19a DATE OF OPERATION Nov 9, 1987 19b CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Lung 20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM ETC) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 9 Nov 19 87 to 12 Nov 19 87, that (I) (we) lost the deceased alive on 12 Nov 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b SIGNATURE (Type or Print) DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c DATE SIGNED Nov 13, 198722d PHYSICIAN'S NAME (Type or Print) ADDRESS  
ROBERT B. WAGNER, M.D. 50 W. Edmonston Dr., Rockville, Md. 20852

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 16 Nov 1987 23c NAME OF CEMETERY OR CREMATORY Chcamuxen Meth Ch 23d LOCATION CITY OR TOWN COUNTY STATE Chcamuxen Calvert Md

24 FUNERAL DIRECTOR'S NAME ADDRESS  
Robert E Wilhelm Funeral Home Suitland Maryland 25a DATE REC'D. BY REGISTRAR NOV 16 1987 25b REGISTRAR'S SIGNATURE

26a DATE OF DEATH NOV 13 1987 26b TIME OF DEATH 9 PM

27a DATE OF DEATH NOV 13 1987 27b TIME OF DEATH 9 PM

28a DATE OF DEATH NOV 13 1987 28b TIME OF DEATH 9 PM

29a DATE OF DEATH NOV 13 1987 29b TIME OF DEATH 9 PM

30a DATE OF DEATH NOV 13 1987 30b TIME OF DEATH 9 PM

31a DATE OF DEATH NOV 13 1987 31b TIME OF DEATH 9 PM

32a DATE OF DEATH NOV 13 1987 32b TIME OF DEATH 9 PM

33a DATE OF DEATH NOV 13 1987 33b TIME OF DEATH 9 PM

34a DATE OF DEATH NOV 13 1987 34b TIME OF DEATH 9 PM

35a DATE OF DEATH NOV 13 1987 35b TIME OF DEATH 9 PM

36a DATE OF DEATH NOV 13 1987 36b TIME OF DEATH 9 PM

37a DATE OF DEATH NOV 13 1987 37b TIME OF DEATH 9 PM

38a DATE OF DEATH NOV 13 1987 38b TIME OF DEATH 9 PM

39a DATE OF DEATH NOV 13 1987 39b TIME OF DEATH 9 PM

40a DATE OF DEATH NOV 13 1987 40b TIME OF DEATH 9 PM

41a DATE OF DEATH NOV 13 1987 41b TIME OF DEATH 9 PM

42a DATE OF DEATH NOV 13 1987 42b TIME OF DEATH 9 PM

43a DATE OF DEATH NOV 13 1987 43b TIME OF DEATH 9 PM

44a DATE OF DEATH NOV 13 1987 44b TIME OF DEATH 9 PM

45a DATE OF DEATH NOV 13 1987 45b TIME OF DEATH 9 PM

46a DATE OF DEATH NOV 13 1987 46b TIME OF DEATH 9 PM

47a DATE OF DEATH NOV 13 1987 47b TIME OF DEATH 9 PM

48a DATE OF DEATH NOV 13 1987 48b TIME OF DEATH 9 PM

49a DATE OF DEATH NOV 13 1987 49b TIME OF DEATH 9 PM

50a DATE OF DEATH NOV 13 1987 50b TIME OF DEATH 9 PM

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72447 NOV 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE R. FENWICK			2a. DATE OF DEATH MONTH DAY YEAR 11-03-87		2b. HOUR 8.08P M					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES MEDICAL CENTER <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Custodian		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Capiotl Heights		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 915 Minna Avenue 20743	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Fenwick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 12 2507		17. INFORMANT ADDRESS Marion V. Fenwick-wife-915 Minna Av					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Constrictive Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Dilated Atherosclerosis, Chronic Renal Failure, Diabetes Mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>N/A</u>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1/83</u> 19 <u>83</u> , to <u>11/3</u> 19 <u>87</u> , that (II) (we) last saw the deceased alive on <u>11/3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Don H. Yablonsky</u>				DEGREE <u>MD</u>			22c. DATE SIGNED <u>11/4/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don H. Yablonsky, MD</u>				22e. ADDRESS <u>10300 Greenbelt Rd. Suite 101 Seabrook, MD 20706</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 7, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D.C.</u>				
24. FUNERAL DIRECTOR NAME <u>John I. Stouffer</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV. 18 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Randall</u>				
Stewart Funeral Home-4001 Benning Road										

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COLLIER

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
*Ruth Virginia Fenwick*

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b. HOUR  
ESTIMATED ☐ 11-18 1987 3:40 A.M.

3. SEX

*Female*

4. RACE

*Black*

5. DATE OF BIRTH

MONTH DAY YEAR  
*Nov 19, 1907*

6. AGE (IN YEARS)

LAST BIRTHDAY MONTHS DAYS HOURS MIN  
*79 YRS.*

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD

19 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

*Washington, D.C.*

7b. CITIZEN OF WHAT COUNTRY?

*USA*

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

*PG*

MD.

10. CITY OR TOWN OF DEATH

*Capitol Heights*

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
*248 Possum Court*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

*Packer (Ret)*

12b. KIND OF BUSINESS OR INDUSTRY

*Organization*

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

*Md.*

13b. COUNTY

*PG*

13c. CITY OR TOWN

*Capitol Hgts*

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

*248 Possum Ct. Capitol Hgts, Md*

14. FATHER'S NAME

FIRST MIDDLE LAST  
*James W. Morris*

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
*Mary Morris*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)  
*no*

16b. SOCIAL SECURITY NO.

*577-58-6019*

17. INFORMANT

ADDRESS

*Doris Frazier; 248 Possum Ct., Capitol Hgts*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Septicemia*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) *Urinary tract infections*

DUE TO, OR AS A CONSEQUENCE OF

*Antigenotoxic cerebro-vascular disease*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
*P.M. 19*

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐

Inspection ☒

Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☒

Accident ☐

Suicide ☐

Homicide ☐

Undetermined manner ☐

ACTUAL SIGNATURE

*Augusto P. Rodriguez*

M.D.

TITLE (SPECIFY)

*Deputy*

MEDICAL EXAMINER

DATE SIGNED

*11-18-87*

EXAMINER'S NAME

(TYPE OR PRINT) *Augusto P. Rodriguez, M.D.*

ADDRESS

*5009 Rayburn Ct., Temple Hills, MD*

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)  
*Burial*

23b. DATE

*11-23-87*

23c. NAME OF CEMETERY OR CREMATORY

*Harmony Memorial Park*

23d. LOCATION

CITY OR TOWN  
*Landover*

COUNTY

*PG*

STATE

*Md.*

24. FUNERAL DIRECTOR

*Marshall's Funeral Home*

25a. DATE REC'D. BY REGISTRAR

*NOV 25 1987*

25b. REGISTRAR'S SIGNATURE

*Julia Davidson-Pulley*

NAME ADDRESS  
*4217 9th Street NW: Washington, D.C.*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DMH - 17  
(VR A15 ME (5))

BP

07/84  
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10M 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

01337 013370

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

*Patrick Tracy Fissell*

2a. DATE KNOWN OF DEATH ESTI- MATED *Nov 11 1987* MONTH DAY YEAR

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

*Washington, D.C.*

*U.S.A.*

*Prince Georges MD*

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

*New Carrollton*

*7710 Riverdale Rd*

*Self Employed*

*Store Manager*

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS

20744

14. FATHER'S NAME

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

MIDDLE

LAST

*Michael*

*C.*

*Fissell*

*June*

*D.*

*Baker*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*No*

*577-02-9128*

*Michael C. Fissell 6910 Eagleton Lane Ft. Washington, Md.*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

*Gunshot Wound of Head*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

*None*

*None*

20. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

*10:11 P.M. 11/11/87*

*Shot self*

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☒

*Parking Lot Riverdale Rd New Carrollton Prince Georges, Md.*

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN

COUNTY

STATE

*Burial*

*11/14/87*

*Resurrection Cemetery*

*Clinton*

*P.G. Maryland*

24. FUNERAL DIRECTOR NAME

25a. DATE REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

*George P. Kalas Funeral Home Oxon Hill, Md.*

*NOV 13 1987*

*Julia Davidson-Randall*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

10 21 JAN 8 80 15

071524 NOV 12 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33293

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Catherine Elizabeth Fisher

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 11/ 6/ 19 87 2b. HOUR AM

3. SEX

Female

4. RACE

Cau.

5. DATE OF BIRTH

10-05-35

6. AGE (IN YEARS)

52

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD 11/ 6/ 19 87 2d. HOUR AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County, MD.

10. CITY OR TOWN OF DEATH

Cheverly

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Prince George's General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince Geo.

13c. CITY OR TOWN

Landover

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

7623 Oxman Road 20785

14. FATHER'S NAME

Joseph

MIDDLE

L.

LAST

Thomas, Sr.

15. MOTHER'S MAIDEN NAME

Lillian

MIDDLE

B.

LAST

Tucker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

-----

17. INFORMANT  
ADDRESS

215-36-5398

Harold S. Fisher, Same as Line #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Multiple Injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

7:30 P.M. 11/ 4/ 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

subject pedestrian struck by auto

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)

roadway

21f. LOCATION

Rt. 202 &amp; John Hansen Hwy. Cheverly, Pr. Geo., Md.

22a. I certify that I took charge of the remains described above, held

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D. Chief

MEDICAL EXAMINER

DATE SIGNED 11/7/87

EXAMINER'S NAME  
(TYPE OR PRINT)

John E. Smialek, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)  
Burial

23b. DATE

11-11-87

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d. LOCATION

Brentwood P.G., Maryland

CITY OR TOWN COUNTY STATE

24. FUNERAL HOME OR

FRANCIS GASCH'S SONS FUNERAL HOME, P.A.

DATE REC'D. BY REGISTRAR

NOV 10 1987

25. REGISTRAR'S SIGNATURE

division - Records

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE REASON IN ITEM 19, AND SIGN AND DATE IN ITEM 22.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH THIS PAGE 3 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, AND 2 HOURS BEFORE BURIAL, AND 2 HOURS BEFORE CREMATION, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))





074195 DEC-7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert	MIDDLE Lemuel	LAST Fleshman	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11-27 1987		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1945	6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-27 1987		2d. HOUR 6:00 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8200 54th Pl., Apt. 3				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. BUSINESS OR INDUSTRY Building Contractor	
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10500 Lanham Severn Road 20706				
14. FATHER'S NAME FIRST MIDDLE LAST Levi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva May Sales		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 219-42-3090		17. INFORMANT (Sister In Law) 4403 Romlon St. Beltsville, Md. 20705							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Jaundice Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Cirrhosis of the Liver (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? (Head Only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) Assistant		DATE SIGNED 11-28-87		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/03/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR DEC - 4 1987		25b. REGISTRAR'S SIGNATURE Julia J. Anderson-Rutledge			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FIGURES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

D7-84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

074102 DEC-73



074128 DEC

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33295

1. DECEASED NAME (TYPE OR PRINT) IRIS ADELAIDE FLETCHER			2a. DATE OF DEATH MONTH DAY YEAR 11 23 87		2b. HOUR 1 45P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 09 10 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE W. Va.		13b. COUNTY Berkeley	13c. CITY OR TOWN Martinsburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route 3 99999
14. FATHER'S NAME FIRST MIDDLE LAST George Binam Love (DEC)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Rebecca Payne (DEC)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 226-14-3830		17. INFORMANT ADDRESS Pat Stranger 204 Parkside Rd. Silver Spg. Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) cardiovascular arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>87</u> , to <u>11/23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. B. H. OSH M.D.		22e. ADDRESS 6510 KENILWORTH AVE, RIVERDALE MD 20737			

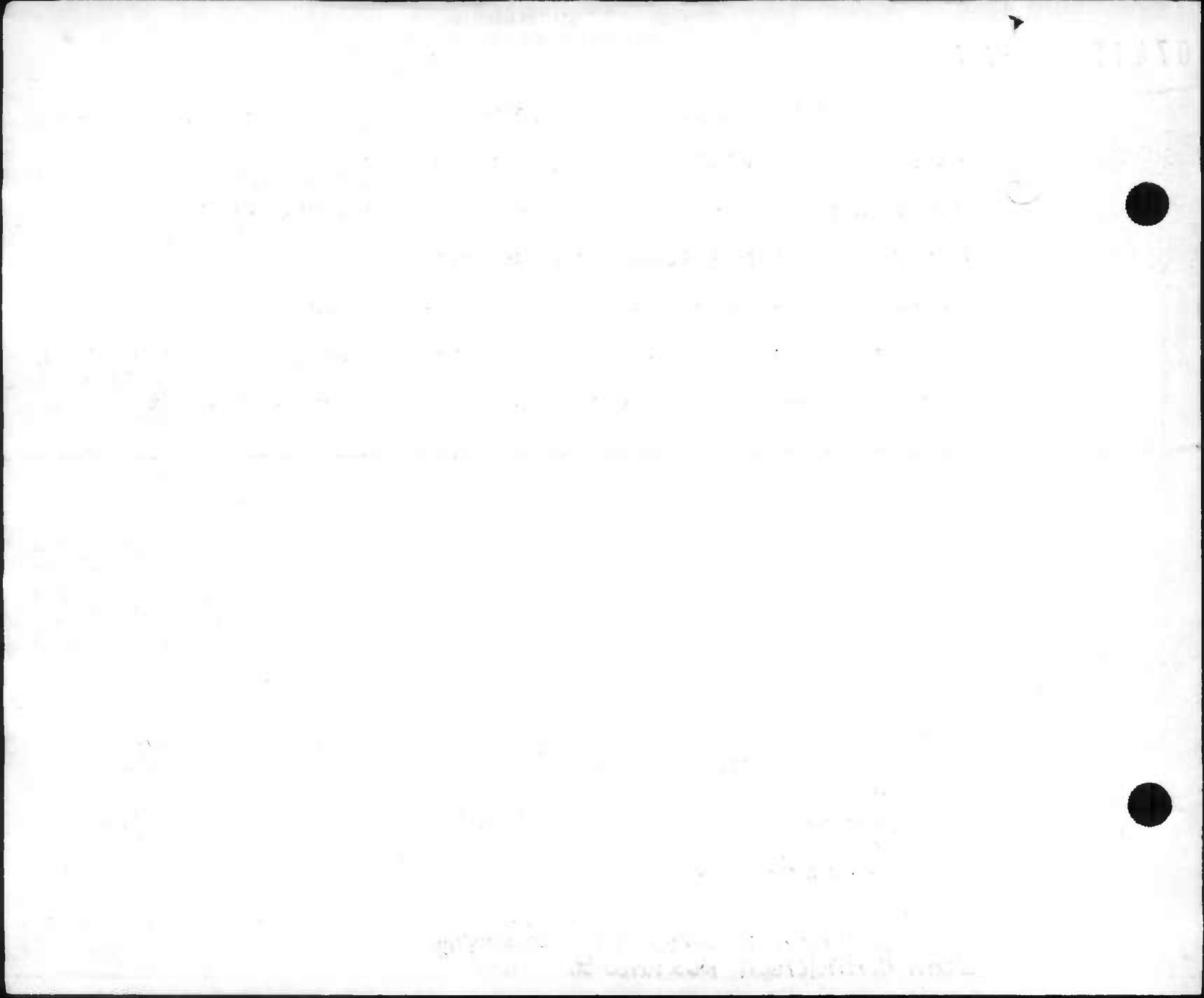
MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Greenway	23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley Spg. Morgan W. Va.
24. FUNERAL DIRECTOR NAME Hunter-Anderson F.H. Berkeley Spg. Md. John A. Anderson 106 S. Mercer St. W.V.		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 01 1987 Julia Anderson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

DECEASED NAME FIRST MIDDLE LAST Arthur Francis FOLGER			2a. DATE OF DEATH MONTH DAY YEAR November 1, 1987		2b. HOUR 6:06p <sup>M</sup>		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 29-1908	6. AGE (IN YEARS LAST BIRTHDAY) 79		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BASTIEN CITY OR COUNTY OF DEATH Prince George's MD				
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, GIVE FACILITY NAME, STREET ADDRESS) Dr's Hospital - Lanham Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Dept. General Confer.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland	13b. COUNTY Prince Geo. Co.	13c. CITY OR TOWN Adelphi	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8500 Adelphi Rd. P.H. Co. Md.			
14. FATHER'S NAME Arthur F.	MIDDLE Folger	15. MOTHER'S MAIDEN NAME Edith May Cropper	16. ADDRESS 8500 Adelphi Rd. P.H. Co. Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR DATES) No		16b. SOCIAL SECURITY NO. 320-34-4699		17. INFORMANT Norethy E. Folger (13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia Lung DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Atherosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK A) WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/17, 1987, to 11/1, 1987, that (I) (we) last saw the deceased alive on 11/1, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
23a. SIGNATURE Monira Rifaat M.D.		DEGREE M.D.		ATTENDING PHYSICIAN MEDICAL EXAMINER		23b. DATE SIGNED 11/2/87	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) Monira Rifaat M.D.		23d. ADDRESS 8118 Goodluck Rd., Lanham, Md. 20706					
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23f. DATE Nov. 5 1987		23g. NAME OF CEMETERY OR CREMATORY Burial Crematory		23h. LOCATION CITY OR TOWN COUNTY STATE Lanham P.H. Md.	
23i. FUNERAL DIRECTOR Takoma Funeral Home		23j. DATE NOV 06 1987		23k. SIGNATURE Takoma Funeral Home		23l. ADDRESS 254 Carroll St. T.H. DC	

MEDICAL CERTIFICATION

7 1 0 5 NOV - 0 0

Handwritten notes and signatures, including "C. J. ...", "Nov 1905", and "C. J. ...".

Handwritten notes and signatures, including "C. J. ...", "Nov 1905", and "C. J. ...".

172423 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33297

1. DECEASED NAME (TYPE OR PRINT) <b>Groce Frances Folks</b>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR MATED <input checked="" type="checkbox"/> <b>11-15-87</b>		2b. HOUR M <b>8:30</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 2, 1912</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>75 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Highland Cty VA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD
10. CITY OR TOWN OF DEATH <b>Oxon Hill</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8406 Sleepy Hollow Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Counter Clerk</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Oxon Hill</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles P. Houlihan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rita M. Varner</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-38-9035</b>		17. INFORMANT ADDRESS <b>Waldorf, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b> M.D.		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>11-15-87</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-19-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hamilton Chapel Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bolar Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Robert E Wilhelm</b>		ADDRESS <b>Suitland, Maryland</b>		
25a. DATE RECD. BY REGISTRAR <b>NOV 18 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Dandridge-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

75452 JUN 10 81

George Thomas Kelly

Franklin

1660 N. 1st St.

Franklin, N. D.

Chapman, D. W.

NOV 18 1981



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
November 19, 1987					5:10 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)
Female		Black		4 14 1939		48 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Georgia		U.S.A.		Prince George		MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Lanham		Doctors Hospital				Nurse
12b. KIND OF BUSINESS OR INDUSTRY		Private				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	
Md.			PG		Landover	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
Robert			Annie E. Hudson		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT	
No			257-48-6164		Robert Fortune/2314 Mathew Henson Ave. P.G.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) Metastatic Colon Cancer Respiratory						
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure						
DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary involvement cancer colon						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/19/87 to 11/18/87, that (I) (we) last saw the deceased alive on 11/16/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE				DEGREE		22c. DATE SIGNED
Marion D. Kelly				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
Marion D. Kelly				7025 Greenway Cr One Greenbelt Rd 20706		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		11-24-87		Harmony Memorial Park		Landover, Pr. Geo., Maryland
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		
NAME ADDRESS				25b. REGISTRAR'S SIGNATURE		
J.B. Jenkins 7474 Landover Rd., Landover, MD				NOV 23 1987 Julia Anderson-Randall		

MEDICAL CERTIFICATION

13 JAN 1964

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

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074695 DEC

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33299

1. DECEASED NAME (TYPE OR PRINT) Mrs. <i>Jimmie</i>		FIRST R.		MIDDLE Foster		LAST		2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 11-30-87		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-30-87		2d. HOUR M 944	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1925		6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Arkansas</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Federal Govt.</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>Prince Geor</i>		13c. CITY OR TOWN <i>Seat Pleasant</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>813 Booker Drive</i>		20743			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Mose Turner, Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Essie Pullum</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577-60-4252</i>		17. INFORMANT <i>Angella Grant</i>		ADDRESS <i>813 Booker Drive</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cerebro-cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertension, senile disorder dementia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TIME (SPECIFY) <i>Reg</i>		MEDICAL EXAMINER <i>Augusto P. Rodriguez MD</i>		DATE SIGNED <i>12-1-87</i>							
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez MD</i>		ADDRESS <i>5507 Laspin Ct, Cap Spr Br Geo Md</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 4, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover, MD.</i>							
24. FUNERAL DIRECTOR NAME <i>Stewart Funeral Home</i>		ADDRESS <i>4001 Benning Road, NE</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 10 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Hordell</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR 15 ME (5))

07402 23070



1820-1830

071516 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers, detach and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR2. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

NORA

Estelle

Fox

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

11

7

87

1150P

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

4

17

05

6. AGE (IN YEARS, LAST BIRTHDAY)

82

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Tennessee

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD.

10. CITY OR TOWN OF DEATH

Riverdale

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Leland Memorial Hospital

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland13b. COUNTY  
P.G.13c. CITY OR TOWN  
Beltsville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

10405 46th Ave., Bldg. B, #102

20705

14. FATHER'S NAME

John

MIDDLE

Kibee

LAST

Shannon

15. MOTHER'S MAIDEN NAME

Nora

MIDDLE

Lee

LAST

Roane

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

578-26-8070

17. INFORMANT

Joseph A. Fox, Son, Same as line #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

LEFT CEREBRAL INFARCT (CUA)

DUE TO, OR AS A CONSEQUENCE OF

WITH COMMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

CARDIAC

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

COPD

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9.27. 1987 to 11.7. 1987, that (I) (we) lost

saw the deceased alive on 11.7. 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above. (I) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

MD

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c. DATE SIGNED

11-08-1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

ASIE S. QADRI

22e. ADDRESS

4700 BEAUVYNN HOUSE RD, Collg Pk

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11-10-87

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d. LOCATION

Brentwood, P.G.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Francis Gasch's Sons Funeral Home

4739 Baltimore Ave., Hyattsville, Md. 20781

25. DATE OF DEATH BY REGISTRAR

NOV 10 1987

25b. REGISTRAR'S SIGNATURE

u

DHMH : 16 60M 7/84

(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit may be forburial papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion Neidecker FRAZIER			2a. DATE OF DEATH MONTH DAY YEAR November 10, 1987		2b. HOUR 6:47A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 19, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR. GEO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CO. Beautician	12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN New Carrollton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6400 85th Place 20784

14. FATHER'S NAME FIRST MIDDLE LAST Charles Neidecker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Graef	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (# YES; GIVE WAR OR DATES) 212-01-4111	17. INFORMANT ADDRESS 15725 Millbrook Lane Warren F. Frazier (Son) Laurel, Md. 20707	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration of gastric content</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic renal failure.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/31</u> , 19 <u>87</u> , to <u>11/10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/9/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>[Signature]</u>	DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA	22e. ADDRESS 4404 Queensbury Rd. Riverdale MD 20737		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/12/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR NOV 17 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

055501 101 10 03



NOV 1 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

## MEDICAL CERTIFICATION

item 16b film G634 12-7-87 sb  
1 - STATE REGISTRAR per funeral home

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 33302

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Furr</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/30/87</b>			2b. HOUR <b>4:50 PM</b>			
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 10 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. DC.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>			
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hosp. Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>18308 Queen Anne Rd. 20772</b>		
13a. STATE <b>md.</b>		13b. COUNTY <b>P.B.</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK FURR SR</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Owens</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>217-12-2127</b>		17. INFORMANT ADDRESS <b>Hazel B. Furr 18308 Queen Anne Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pulmonary Fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/28/87</b> 19____, to <b>11/30/87</b> 19____, that (I) (we) lost saw the deceased alive on <b>11/30/87</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R + PACC</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/1/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R + PACC</b>				22e. ADDRESS <b>Po Box 849 Waldorf Md. PK Waldorf Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/4/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake Mont Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Davidsonville Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>William Reese + Sons Annapolis, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>		25b. REGISTRAR'S SIGNATURE <b>J. S. Friedman-Randall</b>			

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of", "in" are faintly visible.]*

072449 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33303

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Leroy			Fykes			11/ 7/1987		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD	2d. HOUR	
Male	Black	Sept. 25, 1948	38	MONTHS	DAYS	11/ 7/1987	2:36	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania			USA			Prince George's County, MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
College Park			Capital Beltway & Balto./Wash. Pkwy.			Meat Cutter		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			PG			Oxon Hill		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS		
James Fykes			Lois Duck			320 Brocton Road 20745		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
yes			163 40 7735			Gwendolyn Fykes-wife-320 Brocton		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH
PART I DEATH WAS CAUSED BY:								Road
IMMEDIATE CAUSE (a) Multiple Injuries								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
			2:30 P.M. 11/ 7/ 1987		subject driver in multiple auto collision			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			roadway		Capital Beltway & Balto./Wash. Pkwy, Pr. Geo. Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
John B. Smialek, M.D.			Chief			11/8/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
John B. Smialek, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Nov. 13, 1987			Lincoln Memorial Cemetery		
24. FUNERAL DIRECTOR			23d. LOCATION			23e. DATE REC'D. BY REGISTRAR		
Stewart Funeral Home-4001 Benning Road			SUITLAND, MD			NOV 18 1987		
25b. REGISTRAR'S SIGNATURE			25a. REGISTRAR'S SIGNATURE					
Julia Swider-Randall			Julia Swider-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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073045 DEC

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

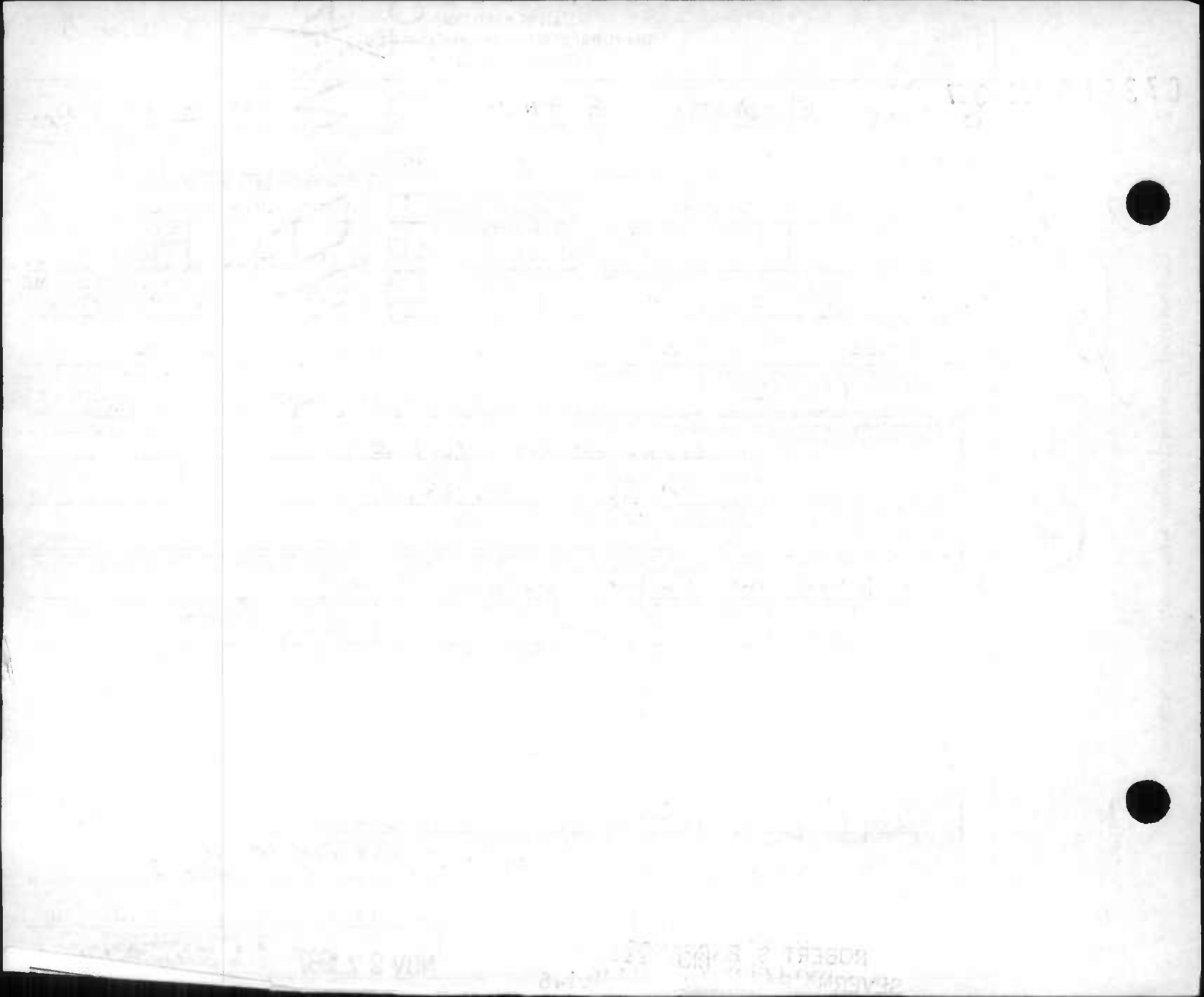
1. DECEASED NAME FIRST MIDDLE LAST <b>Beatrice Elizabeth Gaffney</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 22 87</b>		2b. HOUR <b>8:40 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasion</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 7, 1895</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>South Wales</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS. MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS.	
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gov't Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		13a. STREET ADDRESS / ZIP CODE <b>Bowie, MD 12012 Towanda Ln. 20715</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Shannon</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Brooks</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>	
16b. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT ADDRESS <b>Elizabeth G. Osborne 3-2E Grasonville</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular failure.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cephic shock.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Conjunctive heart failure / pulmonary edema</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <b>Nov 5, 1987</b>					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Conjunctive heart failure / pulmonary edema</b>					
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 5, 1987</b> , to <b>Nov 29, 1987</b> , that (I) (we) last saw the deceased alive on <b>Nov 21, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <b>G.P. Champaloux</b>					
DEGREE <b>M.D.</b>					
22c. DATE SIGNED <b>11/23/87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G.P. CHAMPALOUX, M.D.</b>					
22e. ADDRESS <b>14300 GALLANT FOX LA #110 BOWIE MD 20715</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-25-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring P.G. MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>			
24. FUNERAL DIRECTOR'S NAME <b>ROBERT S. BARRANCO</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Tindon-Rodriguez</b>			
25c. ADDRESS <b>SEVERNA PARK, MD. 21146</b>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. There may be other funeral papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH Ann GAINES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 17 87</b>		2b. HOUR <b>7:45 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 1, 1944</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>42</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Beutician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cosmitology</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Waldorf</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Domenic Firmani</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret M. Menna</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-64-1952</b>		17. INFORMANT ADDRESS <b>Raymond Gaines Same as 13 A-E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>Months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Right Lower Lobe Pneumonia</b>					
19a. DATE OF OPERATION <b>11/15/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>87</b> , to <b>11/17</b> , 19 <b>87</b> , that (I) <del>last</del> saw the deceased alive on <b>11/17</b> , 19 <b>87</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/21/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton Prince George's Md.</b>
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1987</b>		
25b. REGISTERED SIGNATURE <b>[Signature]</b>			25c. REGISTERED SIGNATURE <b>[Signature]</b>		

0135410930



073392 NOV 30-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gladys M Gandy</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-25-1987</i>		2b. HOUR <i>2.10 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 5 18</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS HOURS MIN. <i>69</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges Co MD.</i>	
10. CITY OR TOWN OF DEATH <i>Chesapeake</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St Maryland Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Ft. Washington</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lawrence W. Guillard</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carrie M. Mellott</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-14-6422A</i>		17. INFORMANT ADDRESS <i>James D. Gandy 1505 Ferguson La. Ft. Washington, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>oat cell carcinoma, Lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive pulmonary Disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>10/31</i> , 19 <i>87</i> , to <i>11/25</i> , 19 <i>87</i> , that (I) <del>(lost)</del> saw the deceased alive on <i>11/24</i> , 19 <i>87</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <i>(did)</i> not view the body after death.							
22b. SIGNATURE <i>Cyrus V. Parsey M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/25/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CYRUS V. PARSEY M.D.</i>				22e. ADDRESS <i>8700 old Brunch Ave Clinton MD 20735</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>11/27/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>George P. Kalas Funeral Home</i>				25. DATE REC'D. BY REGISTRAR <i>NOV 27 1987</i>		25b. REGISTRAR'S SIGNATURE <i>J. A. Jackson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy to page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be certified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

Items 5, 6 Film G634 12/9/87 jab

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 33307

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Violet A. Gavin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 3 1987</b>			2b. HOUR A M <b>9:00 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 15, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>79-80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George MD</b>	
10. CITY OR TOWN OF DEATH <b>Mitchellville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Villa Rosa Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>10320 Crown Point Ct./20854</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas J. Williams</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Schneider</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-80-5430</b>		17. INFORMANT ADDRESS <b>Ralph A. Wells, Same address as #13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conditio - Pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septicemia, Possible</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ALZHEIMER'S Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus Congestive heart failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>8-12-1986</b> to <b>11-3-1987</b> , that (I) <del>was</del> last saw the deceased alive on <b>11-3-1987</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (I) <del>was</del> (did) <del>not</del> view the body after death.							
22b. SIGNATURE <b>R. and 9</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/3/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAKESH ALOA</b>		22e. ADDRESS <b>114300 GALLANT FOX LN, BOWIE MD 20715</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/6/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Military Academy Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>West Point, NY</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Friedman-Palmer</b>	
ADDRESS <b>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>							

16 81 VCH 883170



072452 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED				MONTH DAY YEAR				2b. HOUR					
Harold L. Gehron						11 15 19 87								M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				2d. HOUR			
Male		White		4 21 1930		57 YRS.						11 15 19 87				8:18 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania				U. S. A.				WIDOWED				Prince George's County, MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK)				12b. KIND OF BUSINESS OR INDUSTRY							
Cottage City				3207 38th Avenue				Brick Mason				Construction							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland				Prince George's				Cottage				YES				3207 38th Street			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
Henry L. Gehron				Laura Belle Stotz															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
Yes				411-40-3586				Deborah Grisar				4103 30th Street Mt. Rain-							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?			
																HEAD ONLY YES NO			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
								STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Margarita A. Korell, M.D.				Assistant				11/16/87											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Margarita A. Korell, M.D.				111 Penn St.				Balto. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				11-21-87				Woodlawn Cemetery				Knoxville, Knox, Tennessee							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Marzullo Funeral Service				Upperco, MD.				NOV 18 1987				Julia Davidson							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (GENERAL PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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NOV 18 1983

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 33309

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MILDRED GERMANO			2a. DATE OF DEATH MONTH DAY YEAR 11 30 87		2b. HOUR 4:25AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 03 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Film Splicer		12b. KIND OF BUSINESS OR INDUSTRY Bonded Film Co.
13a. STATE Maryland		13b. COUNTY Prince George's	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Amendolario		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Gentile			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 052-03-4843		17. INFORMANT ADDRESS Elaine Prego, 5618 Quincy Street Hyattsville, MD 20784	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Cerebrovascular Accident, Anemia, upper GI bleed</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>87</u> , to <u>11/30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Don H. Yablonski</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>11/30/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don H. Yablonski</u>		22e. ADDRESS <u>10300 Greenbelt Rd., #101 Seabrook, Md 20706</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-2-87	23c. NAME OF CEMETERY OR CREMATORY Fresh Pond Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Middle Village, New York
24. FUNERAL DIRECTOR NAME Geis Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 03 1987	
57-34 Catalpa Avenue, Ridgewood, NY 11385		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pandey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1957

DEC 03 1957



073829 DEC-31

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33310

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			2b. HOUR				
James Madison Gheen												Nov. 20, 1987							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			7d. HOUR				
M		W		Nov 22 1979		79 YRS.						Nov. 24, 1987			1987				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia				U.S.A.								Prince Georges				MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Brentwood				4409 38th St.				Heavy Equip. Oper.				Construct.							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
MD				Prince Georges				Brentwood				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				4409 38th St 20722			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
James Ernest Gheen				Susie Hinson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
Yes				WWII				577-26-1683				6917 Farragut Ave., Falls Church				Mr. Randolph Gheen, Son, Va. 22042			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular sys.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
<u>None</u>												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				M.D.				MEDICAL EXAMINER				DATE SIGNED			
<u>John S. Rogers</u>				M.D. <u>Dep.</u>												Nov. 24, 1987			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
John S. Rogers				1919 Seminary Rd. Silver Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				11-28-87				Ft. Lincoln Cemetery				Brentwood, P.G., Maryland							
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home 4739 Baltimore Ave., Hyattsville, Md. 20781																			
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																			
DEC 02 1987 <u>John S. Rogers</u>																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3, RETURN PAGE 3 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
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1941 - 1942

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1967 - 1968

1969 - 1970

1971 - 1972

072713 NO 12387

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MAELING			MIDDLE M.			LAST GIDDARIE			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 11 18 1987			2b. HOUR M 12:10 A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 18 1965		6. AGE (IN YEARS) (LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 18 19 87			2d. HOUR M 12:10 A M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jamaica				7b. CITIZEN OF WHAT COUNTRY? Jamaica				8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD							
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secty.				12b. KIND OF BUSINESS R-Dulley Wall & associates					
13a. STATE Maryland										13b. COUNTY Pr. Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3520 Oliver Street 20782			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Giddari						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Henry													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Pauline Henry-mother-(same as 13e)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 7:30 P.M. 11-17- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by motor vehicle.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6000 blk. Queens Chapel Rd., near Oliver St., Hyattsville Prince George's MD											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Deputy Chief						DATE SIGNED 11-18-87							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov 25, 1987		23c. NAME OF CEMETERY OR CREMATORY Giddari Family Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Kingston Jamaica									
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Homes						11800 N.H. Ave Silver Spring, Md:				25a. DATE REC'D. BY REGISTRAR NOV 20 1987				25b. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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202-110M-18E2

73504 DEC - 1 1987 FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
GERTRUDE I. GIELEN						NOVEMBER 25, 1987			3:10 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		MONTH DAY YEAR SEPT 2 1916		71 YRS.			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
NEW YORK		USA				PRINCE GEORGES MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BOWIE		6811 IRENE COURT				STOCK BROKER			JOHNSTON-LEMON			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
MARYLAND				PR GEORGES		BOWIE		YES <input type="checkbox"/> NO <input type="checkbox"/>		6811 IRENE COURT 20715		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST CARL JOHN BATTER				FIRST MIDDLE LAST CERTRUDE IRENE BEYER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO				349-09-7095		PRICE O. GIELEN/SON/SAME AS 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRAL ATROPHY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>4 MONTHS</u> <u>1 YEAR</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>SMALL CELL LUNG CANCER</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased on <u>July 23, 1983</u> to <u>NOVEMBER 24, 1987</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 24, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>sign the body after death</u> .												
22b. SIGNATURE <u>Harold Mirsky</u>								DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>11/25/87</u>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD MIRSKY								22e. ADDRESS 2400 H STEET, NW SUITE 7 WASHINGTON, D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL				NOV 28, 1987		PARKLAWN CEMETERY		ROCKVILLE MONTGOMERY MARYLAND				
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		
								NOV 30 1987				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 31 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified by the funeral director.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

DECEASED NAME (PRINT OR PRINT)			2a DATE OF DEATH			2b HOUR		
WILLIAM E. GILES			11-10-87			5.30P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Caucasian	1-22-1919	68 YRS			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington D.C.	U.S.A.		PRINCE GEORGES MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER		Engineer			Safeway Store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE		
13a STATE Maryland 13b COUNTY Prince Geo. 13c CITY OR TOWN Hyattsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4033 Ingraham St., 20781		
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Emerson W. Giles			Forrest Gayle					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS					
Yes		WW-2	219-03-0653 Dorothy A. Giles, Same as Line #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary artery disease</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) <u>Renal failure</u>								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10/87</u> to <u>11/11/87</u> , that (I) (we) lost saw the deceased alive on <u>11/10/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
<u>S. P. R. J. A.</u>		MD				11/14/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
		8804 PG 6 HOSPITAL CHEVERLY MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		11-13-87		Ft. Lincoln Cemetery		Brentwood, P.G., Maryland		
FRANCIS GASCH'S SONS FUNERAL HOME, P.A.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
4739 Baltimore Ave., Hyattsville, Maryland				NOV 17 1987		Julia Davidson-Randall		

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. This permit must be given to the funeral home within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDYTHE M GOFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 26 87</b>		2b. HOUR <b>12:05A<sub>M</sub></b>
3. SEX <b>F</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HRS. MIN. <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD</b>	
10. CITY OR TOWN OF DEATH <b>Laurel</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel/Beltsville Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl Griffith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora Burkey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>		16b. SOCIAL SECURITY NO. <b>705-10-8487</b>		17. INFORMANT <b>Donald Goff</b>	
		ADDRESS <b>9245 Livery Lane</b>		<b>Laurel, MD 20707</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IRREVERSIBLE HYPOTEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>FIBROSING ALVEOLITIS SEVERE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>PULMONARY ARTERY HYPERTENSION, CORONARY ARTERY DISEASE, RHEUMATOID ARTHRITIS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>19</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>11-26</b> , 19 <b>87</b> , to <b>11-26</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <b>E. S. Machado</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/26/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. S. MACHADO MD</b>		22e. ADDRESS <b>321 PRINCE GEORGE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-28-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Meml. Gardens</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale - Allegany - Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>George-Upchurch Funeral Home, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC - 4 1987</b>			
25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Feb 12

072525 NOV 20 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HAROLD J. GOODMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 17, 1987</b>		2b. HOUR <b>9:28AM</b>		
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/29/29</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>58</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD	
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince Ge.</b>		13c. CITY OR TOWN <b>Laurel</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harold J. Goodman, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea 220-20-3552</b>		17. INFORMANT ADDRESS <b>Harold J. Goodman 3131 Ryerson Circle 21227</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYO CARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> , 19 <b>87</b> , to <b>11/17</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>ABOUT 11/10</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>G.A. Compton MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-17-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G.A. COMPTON MD</b>				22e. ADDRESS <b>5317 Cherry Lane Laurel MD 20707</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/20/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Anne Arundel Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home</b>				ADDRESS <b>1328 Sulphur Spring Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>	
				25b. REGISTRAR'S SIGNATURE <b>John R. Randall</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

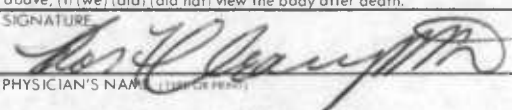
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or blank, it shows any injury, or other traumatic event, the medical examination must be notified of.



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Shirley A. Gordon</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 25, 1987</b>		2b. HOUR <b>1:05 M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 3, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges MD.</b>	
10. CITY OR TOWN OF DEATH <b>Clinton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Waldorf</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>424 Lake Drive / 20601</b>
FATHER'S NAME FIRST MIDDLE LAST <b>John C. Dean</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Joy</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>577-84-8276</b>		17. INFORMANT <b>Elizabeth Rice</b>		ADDRESS <b>9543 Old Creek Drive Fairfax, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b> 25 days DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Artery Disease</b> 25 days DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Disease</b> 10 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>MAR 6</b> , 19 <b>79</b> , to <b>Nov 25</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>Nov 25</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE 		DEGREE		22c. DATE SIGNED <b>Nov. 27, 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas Cleary, M.D.</b>		22e. ADDRESS <b>9131 Piscataway Rd. Clinton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov 30, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>		ADDRESS <b>Clinton, Maryland</b>		25. DATE RECEIVED BY REGISTRAR <b>DEC 02 1987</b>	
				25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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Garment made of 20% cotton fiber  
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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (PRINT) Ralph Lee GRAY			2a. DATE OF DEATH MONTH DAY YEAR November 17, 1987			2b. HOUR A M 12:20	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 3, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.	
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS HOSP'T.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GREASER		12b. KIND OF BUSINESS OR INDUSTRY GRAYHOUND BUSCO	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY P.G.C..		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALLIE E. GRAY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA LEE HENDERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS MARJORIE A. GRAY (SAME AS ITEM #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic bronchiectasis &amp; arteriosclerotic cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Chronic obstructive pulmonary disease, severe arterial disease, heart block &amp; cardiac arrhythmias, diabetes &amp; anemia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-12-87</u> , 19 <u>87</u> , to <u>11-16-87</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11-16-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mohammed A. Mannan MD				22c. DATE SIGNED 11.17.87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOHAMMED A. MANHAN	
22e. ADDRESS 3715 - RHODE ISLAND AVE MT. RAINIER, MD. 20712							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-20-1987		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NAT'L CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				25a. DATE REC'D. BY REGISTRAR NOV 25 1987			

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1- FOR UNK.#87-113  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 3 3 1 8

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR			
RUDOLPH		GRAY						XX		11-6		19		87				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
M		B		2 3 55		31 YRS.		MONTHS		DAYS		HOURS		MIN		11-6		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Temple Hills		3200 blk. Lassie Avenue				Prince George's County, MD.															
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Temple Hills		3200 blk. Lassie Avenue																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
N.Y.				BRONX		YES <input type="checkbox"/> NO <input type="checkbox"/>		2060 BLACK ROCK AVE.													
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Multiple Gunshot Wounds and Stab Wounds		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
Canditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF																	
		(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR P.M. 11-5 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		subject was shot and stabbed															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
		street		3200 blk. Lassie Ave.,		Temple Hills,		Prince		George's Co., Md.											
22a. I certify that I took charge of the remains described above, held an death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>																	
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201		DATE SIGNED		11-6-87											
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE											
Removal		11-13-87																			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
State Anatomy Board		Balto., Md.		NOV 16 1987		John Davidson-Randall															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM McLENNON GROVES II</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 5 1987</b>		2b. HOUR <b>8:55A</b> M
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 28, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.		
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <b>AMT Doctors Hospital of Pr. Geo.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Co. CONTRACTOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>LANDOVER</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>8624 REICHER STREET 20785</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM McLENNON GROVES</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA GRAY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-44-9795</b>	17. INFORMANT ADDRESS <b>MRS. REBECCA GROVES, 8624 REICHER STREET LANDOVER, MD. 20785</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pancreatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 20</u> , 19 <u>87</u> , to <u>Nov 5</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>James Chesley</i>			DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/5/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Chesley, M.D.</b>			22e. ADDRESS <b>Parron Bldg., First Street Indian Head, Md. 20640</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/9/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>IMMACULATE HEART OF MARY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LEXINGTON PARK, ST. MARY'S, MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

NOV 10 1961

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR NAME)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Henry B. Guyther, SR.				November 19, 1987		5 10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		CAUCASIAN		MARCH 8 1905		82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				Prince Georges County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
LAUREL		Greene Laurel Beltsville Hospital		PAVING CONTRACTOR			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		PR GEORGES		LANDOVER HILLS		7201 BUCHANAN STREET 20784	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
CHARLES HENRY GUYTHER, SR.		MARY ROSA BEAL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		578-10-1113		MARY D. GUYTHER/WIFE/SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>87</u> , to <u>11/19</u> , 19 <u>87</u> , that (I) (we) lost <u>11/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul Parkhurst</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/19/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PARKHURST MD</u>		22e. ADDRESS <u>7100 BALT. AVE #901 COLLEGE PARK MD 20740</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>NOV 23, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BRENTWOOD PRINCE GEORGES MD</u>	
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS, JR.</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 25 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 3 3 3 2 1

1. DECEASED NAME (TYPE OR PRINT) Edna -- Haire			2a. DATE OF DEATH MONTH DAY YEAR October 20, 1987			2b. HOUR P. M. 9:06 P.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 11, 1886		6. AGE (IN YEARS LAST BIRTHDAY) YRS 100		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Upper Marlboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14200 Rutherford Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY House of Representatives (U.S. Congress)		
13a. STATE Maryland			13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 14200 Rutherford Rd/20870	
14. FATHER'S NAME FIRST MIDDLE LAST Robert H. Haire			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen -- Sargent							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----		17. INFORMANT ADDRESS Virginia Flatley-Marlboro, Md. 20772						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>2/5</u> , 19 <u>78</u> , to <u>10/20</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>9/22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert M. Nedzbala</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/22/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. Nedzbala, M.D.				22e. ADDRESS 11701 Livingston Rd., Fort Washington, Maryland 20744						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/23/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland (Pr. Geo's) Md.				
24. FUNERAL DIRECTOR Richard A. Coleman Funeral Home				-Upper Marlboro, Maryland 20772		25a. DATE REC'D. BY REGISTRAR NOV 16 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This low cost certificate is to be retained by the hospital or attending physician. It should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified and a medical investigation may be required.

NOV 15 1961



NOV 15 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DMH-10-16-80M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		7. BALTIMORE CITY OR COUNTY OF DEATH	
7b. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. PRINCE GEORGES		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. HUMAN RESOURCES		12b. GOVT.		13. STREET ADDRESS / ZIP CODE		14. INSIDE CITY LIMITS?		15. MOTHER'S MAIDEN NAME	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. 4151 MINN. AVE. N.E. #8		13f. 99999		15. MAMMIE ELAM	
14. FATHER'S NAME		14. JOHN E. HALL		15. MOTHER'S MAIDEN NAME		15. MAMMIE ELAM		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
16a. NO		16b. n/a		16c. 093-14-9922		17. RUTH A.H. FORTUNE		17. 4151 MINN. AVE NE		17. WASHINGTON, D.C.		17. WASHINGTON, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:										1-2 Day			
IMMEDIATE CAUSE (a) <u>Hepatic coma</u>										2 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>Carcinoma of the prostate</u>			
DUE TO, OR AS A CONSEQUENCE OF										(c) <u>2 yrs</u>			
DUE TO, OR AS A CONSEQUENCE OF										(d) <u>2 yrs</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION		CITY OR TOWN			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21j. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21k. 11/13				21l. 11/13		21m. 11/13		21n. 11/13		21o. 11/13	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> 19 <u>87</u> , to <u>11/13</u> 19 <u>87</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE				22d. DATE SIGNED		22e. ATTENDING PHYSICIAN		22f. MEDICAL DIRECTOR		22g. STAFF PHYSICIAN	
22b. CHARLES COLAO M.D.		22c. M.D.				22d. 11/14/87		22e. <input checked="" type="checkbox"/>		22f. <input checked="" type="checkbox"/>		22g. <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE		22h. NOV 25 1987			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY		23g. STATE	
23a. BURIAL		23b. 11-19-87		23c. MD. NATIONAL MEM.		23d. LARUEL		23e. BALTIMORE		23f. BALTIMORE		23g. MARYLAND	
24. FUNERAL DIRECTOR		24. JOHNSON & JENKINS FH., INC.				25. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE		25. NOV 25 1987			
24. 716 KENNEDY STREET N.W.		24. BALTIMORE, MD.				25. NOV 25 1987		25. <u>Arin Friedman-Randall</u>		25. BALTIMORE, MD.			

MEDICAL CERTIFICATION

053304 000050

NOV 20 1964

073399 NOV 30 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DELMAR HARMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 21 87</b>			2b. HOUR <b>2:30P M</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 20 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BELTSVILLE HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tire Builder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Howard</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Box 111 20701</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Harman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Barkley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW11</b>		17. INFORMANT <b>Carolyn Harman</b>		ADDRESS <b>Box 111 Annapolis Jct. MD 20701</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Carcinoma of larynx. cerebro-vascular accident</b>									
19a. DATE OF OPERATION <b>10/27/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>deculitus left foot</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/14/1987</b> to <b>11/21/1987</b> , that (I) (we) last saw the deceased alive on <b>11/20/1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE <b>Abdul Nayeem M.D.</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/21/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL NAYEEM, M.D.</b>				22e. ADDRESS <b>3450 FORT MEADER LAUREL, MD 20707</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/24/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Akron Summit Ohio</b>			
24. FUNERAL DIRECTOR <b>Black Funeral Home Inc</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			
7601 Sandy Spring Rd Laurel MD 20701									

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072446 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CORNELIUS HARRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 30 87</b>		2b. HOUR <b>10 30PM</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 21, 1938</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITY OR TOWN OF BIRTH <b>States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES HOSPITAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Distributor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Quality Snack</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Forestville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ora Harris</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579 50 1373</b>		17. INFORMANT ADDRESS <b>Tonya Harris-daughter-146 42nd St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Brain Damage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. <b>Tonsillar Carcinoma - Chronic Renal Failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>Sept 30</b> 19 <b>87</b> , to <b>Oct 30</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>Oct 30</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>MD MRCP</b>				DEGREE <b>MD MRCP</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 6, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>John I. Stewart</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
26. FUNERAL HOME <b>Stewart Funeral Home-4001 Benning Road,</b>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

(1)





## CERTIFICATE OF DEATH

REG. NO.

071590 NOV 12 1987

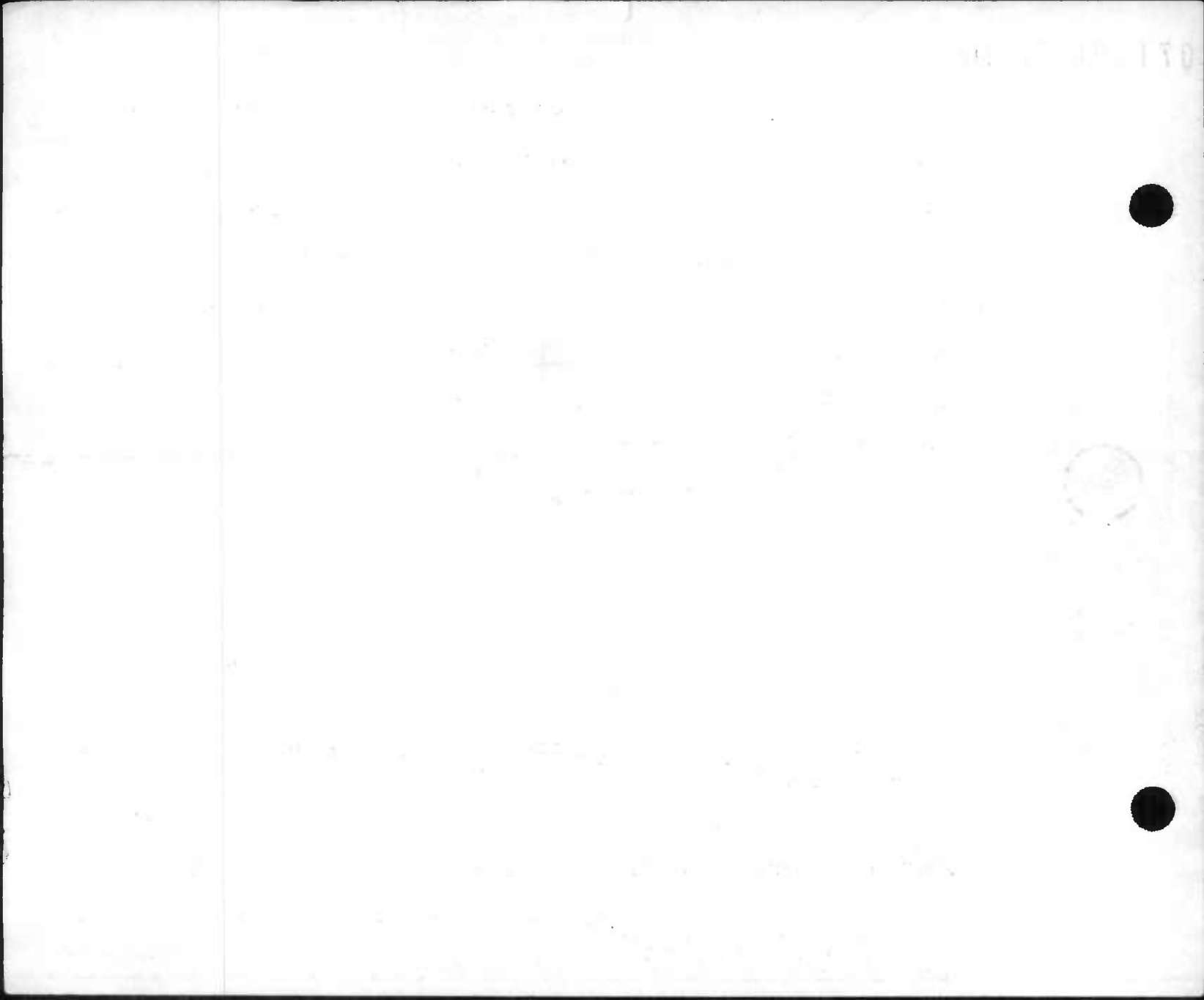
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT CLARENCE HARRISON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCT 28 1987</b>		2b. HOUR <b>5:00a.m.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 28, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa Idaho</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Andrews</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Malcolm Grow Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret Military</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Virginia</b>				13b. CITY OR TOWN <b>Fairfax</b>		13c. STREET ADDRESS / ZIP CODE <b>4211 Lenox Dr. 22032</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roy C. Harrison</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Dwiggins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Martha L. Harrison See #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASYSTOLE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <b>27 OCT</b> 19 <b>87</b> to <b>28 OCT</b> 19 <b>87</b> , that <b>XX</b> (we) lost saw the deceased alive on <b>28 OCT</b> 19 <b>87</b> , and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>XX</b> (we) (did) not view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>28 OCT 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LIBERATUS A. DEROSA, MAJ, USAF MC</b>				22e. ADDRESS <b>MGUSAFMC, ANDREWS AFB MD 20331-5300</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/30/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Everly Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 03 1987</b>		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or give.



073219 NOV 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP \_\_\_\_\_

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 33327

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		ISABELLE L. HARTSING		11-22-87		10:55A <sup>M</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		11-6-11		76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ohio		USA				PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PRINCE GEORGE'S HOSPITAL CENTER		office manager		US DA	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE	
MD		Prince George College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4718 Muskogee St. 20740	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Curtis		Nettie		No			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
579-42-5620		Tyler F. Hartsing Sr.		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>Acute Liver Failure</u>		1 month					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic Liver Disease</u>		4 years					
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>Chronic Obstructive Pulmonary Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> 19 <u>87</u> , to <u>11/22</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/22</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		<u>GABRIEL JAFFE, M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
GABRIEL JAFFE, M.D.		7500 HANOVER AVE		Greenbelt MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation		11/23/87		Metropolitan Crematory		Alexandria Fairfax Virginia	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donald V. Borgwardt 4400 Powder Mill Rd Beltsville Md 20705		NOV 25 1987		Julia Anderson-Randall			

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NOV 25 1961  
J. F. Thompson

072736

NOV 23 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 3 3 3 2 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Nathaniel PAUL Harvey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 15 1987</b>		2b. HOUR <b>10 PM</b>		
3. SEX <b>male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 17 13</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS HOURS MIN. <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES MD.</b>	
10. CITY OR TOWN OF DEATH <b>ADELPHI</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRESIDENTIAL WOODS NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAINTANANCE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>UNIV. MANOR</b>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>802 UNIVERSITY BLVD EAST 20903</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>BOYD N. HARVEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTIE MAE LIPSCOMB</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-10-1027</b>		17. INFORMANT ADDRESS <b>SON 11917 VIEWCREST DALE J. HARVEY/TERRACE SILVER SPRING, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute aspiration pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							20902 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>27h</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Centro Vanuex accident</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2309 STOREFIELD RD WHEATON MD</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/11 1987</b> to <b>11/15 87</b> , that (I) (we) last saw the deceased alive on <b>11/15 87</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Myron L. Lenkin MD</b>				22c. DATE SIGNED <b>11/16/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>	
22e. ADDRESS <b>2309 STOREFIELD RD WHEATON MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV 18, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS, JR.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1987</b>			
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 202-359-9035.

BP

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NOV 30 1987

071971 NOV 17 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 33329

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES WALKER HARVILL			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 7 1987			2b. HOUR 10:09A M				
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 6, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) East Point, GA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD				
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Eng		12b. KIND OF BUSINESS OR INDUSTRY Ret Militar		
13a. STATE Maryland					13b. COUNTY Pr George		13c. CITY OR TOWN District Hts		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Harvill					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Martin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1942-1962		17. INFORMANT Beverly Harvill		ADDRESS Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INANITION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>TUMOR AND VASCULAR DISEASE</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 20 AUGUST 87, 1987, to 7 NOVEMBER 87, 1987 that (I) (we) last saw the deceased alive on 7 NOVEMBER 87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Terence M. Quigley</i>						DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7 NOVEMBER 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERENCE M. QUIGLEY						22e. ADDRESS MALCOLM GROW MED CEN, AAFB, MD 20331-5300				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10 Nov 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md			
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home						ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR NOV 16 1987		
25b. REGISTRAR'S SIGNATURE <i>John R. ...</i>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then make and file carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other" (Shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ERIE G. HASTY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 10, 1987</b>			2b HOUR 2 <b>10</b> A M	
3 SEX <b>MALE</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug 19, 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10 CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Manor Nursing Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate Broker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Ellis Hasty</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Tillman</b>		13e STREET ADDRESS <b>4922 LaSalle Rd. 20785</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>WW 1 218-32-6187</b>		17 INFORMANT <b>Dr. Mary H. Greer/sister/ Nashville, Tn.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE LEFT LOWER LOBE PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC CARDIORENEAL VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>5 DAYS</b> <b>YEARS</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CHRONIC RENAL FAILURE</b>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>JANUARY</b> 19 <b>83</b> , to <b>NOVEMBER 10</b> 19 <b>87</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>NOVEMBER 9</b> 19 <b>87</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) (did not) view the body after death.							
22b SIGNATURE <b>Marta Anne Schneider M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11/10/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTA ANNE SCHNEIDER M.D.</b>				22e ADDRESS <b>5401 MACARTHUR BLVD NW WASH DC 20016</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>11-14-87</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Marshall's Funeral Home</b> ADDRESS <b>4217 9th St NW: Washington, D.C.</b>				25a DATE REC'D. BY REGISTRAR <b>NOV 23 1987</b>		25b REGISTRAR'S SIGNATURE <b>Julia Swider-Randall</b>	

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1070



072523 NOV 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Claudia A. HATCH			2a. DATE OF DEATH MONTH DAY YEAR November 16, 1987		2b. HOUR 12:50A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR OCT 9, 1946		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital of Pr. Geo.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY University/MD

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Pr. George's	13c. CITY OR TOWN Mitchellville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5700 Avondale Drive 20716
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14. FATHER'S NAME FIRST MIDDLE LAST Crance Wright			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Phipps		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-48-7406	17. INFORMANT Harold James Hatch	ADDRESS 5700 Avondale Drive Mitchellville, MD 20716
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <u>October 24, 1987</u> to <u>November 16, 1987</u> , that (I) (we) last saw the deceased alive on <u>Nov. 16, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
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22b. SIGNATURE <u>Ata Moshvedi</u>	DEGREE	22c. DATE SIGNED 11-16-87
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ata Moshvedi, M.D.	22e. ADDRESS 5632 Annapolis Rd., Suite 7 Bladensburg, Md. 20710
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE NOV 18, 1987	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Pr. George's, MD
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24. FUNERAL DIRECTOR NAME Beall Funeral Home	ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043	25a. DATE REC'D. BY REGISTRAR NOV 19 1987	25b. REGISTRAR'S SIGNATURE
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 3 3 3 3 2

1. FOR  
STATE  
REGISTER2. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ALICE MARIE HAWKINS

2a. DATE OF DEATH MONTH DAY YEAR 11 4 1987 2b. HOUR 6 45 AM

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

June 6, 1911

6. AGE (IN YEARS LAST BIRTHDAY)

76 YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S MD

10. CITY OR TOWN OF DEATH

CLINTON MD

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SOUTHEAST MARYLAND Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

St. M

13c. CITY OR TOWN

Mechanicsville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

P.O. Box 444 / 20659

FATHER'S NAME FIRST MIDDLE LAST

John

MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

Brooks

Rosie

Butler Apt. 302

14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

14b. SOCIAL SECURITY NO.

218-30-26058

14c. INFORMANT

Daughter Shirley Ann Sweetney Washington, D.C.

ADDRESS 1341 Howard Rd. SE.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CARCINOMA of colon

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22a. I certify that (I) (this hospital) attended the deceased from 10/15, 1987, to 11/4, 1987, that (I) (we) last saw the deceased alive on Nov 3, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

Nov 4-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Helen CAPONE MD

22e. ADDRESS

7501 SHARRATTS Rd #105 CLINTON MD 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

11-05-87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Crematory Suitland, P.G.

23d. LOCATION CITY OR TOWN COUNTY STATE

MD.

24. FUNERAL DIRECTOR NAME ADDRESS

Mattingley Funeral Home, Leonardtown, MD

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

NOV 09 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

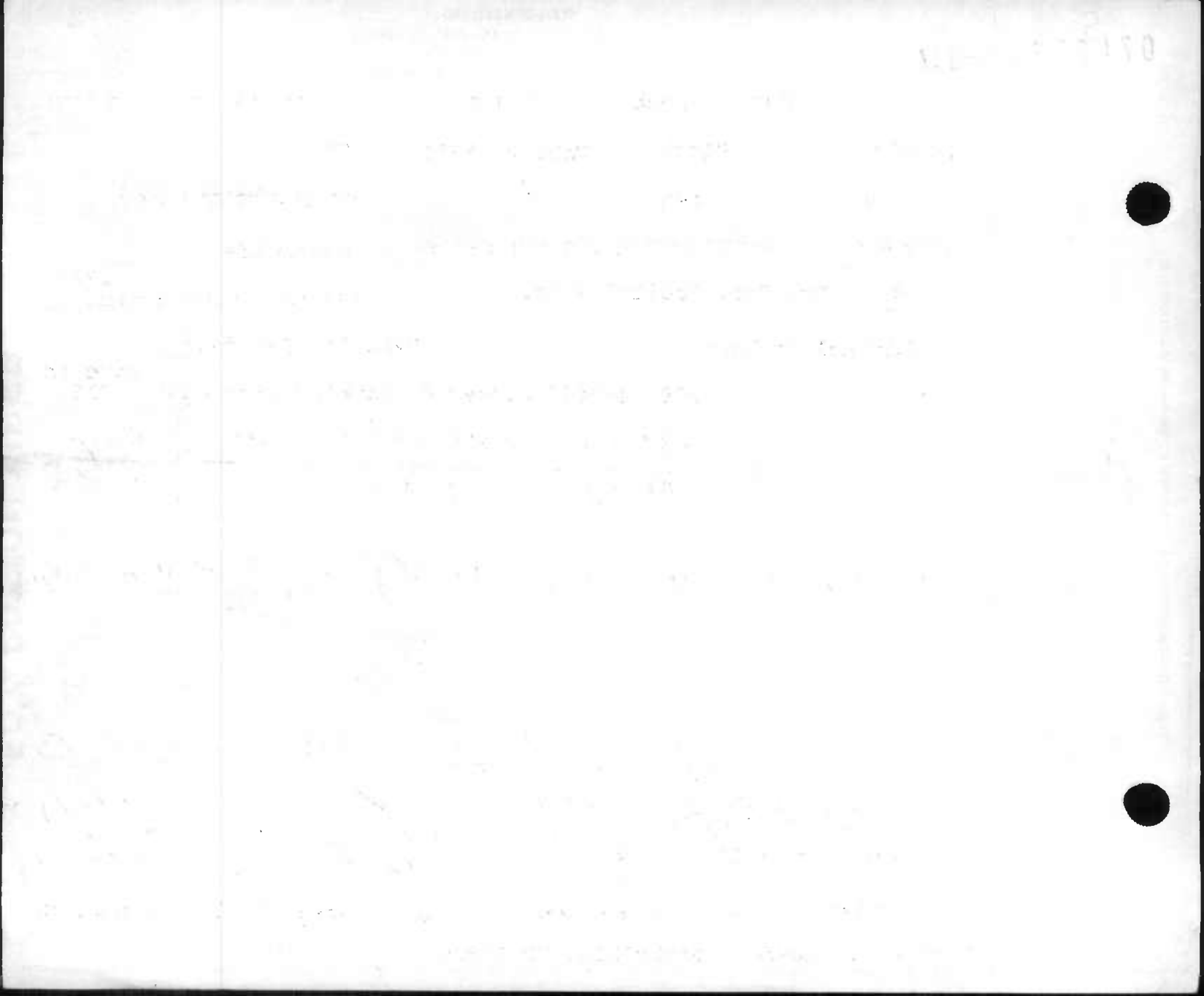
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE Ruth HAWKINS			2a. DATE OF DEATH MONTH DAY YEAR 11 30 87		2b. HOUR 5 30PM M					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1915		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Capitol Hgts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 404 Larchmont Avenue 20743	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Jackson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Snowden						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-30-3445		17. INFORMANT ADDRESS Lester F. Hawkins (Husband)			same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recto-intestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>day</u> <u>week</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>urinary tract infection; renal failure; cardiac arrhythmia</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/7/87</u> 19 <u>87</u> to <u>11/30/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Cesar Soriano Jr.</u> MD			DEGREE			22c. DATE SIGNED 12/1/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR SORIANO JR.			22e. ADDRESS 119 Capitol Hill Bldg Capitol Hill, Md 20743							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-5-87		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. MD			
24. FUNERAL DIRECTOR NAME George R. Snowden Rockville, MD 20850					25a. DATE REC'D. BY REGISTRAR DEC 04 1987					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

051-0-150





## CERTIFICATE OF DEATH

REG. NO.

073642 DEC 28

FOR  
STATE  
REGISTRAR

per funeral home

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Cope HEADRICK <del>HEADRICKS</del>			2a. DATE OF DEATH MONTH DAY YEAR November 27, 1987		2b. HOUR 6:50 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1922		6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Eng.		12b. KIND OF BUSINESS OR INDUSTRY Naval Research
13a. STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Greenbelt	
14. FATHER'S NAME FIRST MIDDLE LAST James Henry Headrick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mertie Alice Cope			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 450-05-5158		17. INFORMANT ADDRESS James M. Headrick 4303 Sarasota Place Beltsville, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARD, CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>sublethal abdominal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/25/87</u> , 19 <u>87</u> , to <u>11/27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. GHOSH				22e. ADDRESS 6510 KENILWORTH AVE #1400 RIVERDALE, MD 20732		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 1987		23c. NAME OF CEMETERY OR CREMATORY Citizen's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clarendon, Texas
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Arlington, Va.				25a. DATE REC'D. BY REGISTRAR DEC 01 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

9  
9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Estelle M. Heim</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 22, 1987</b>		2b. HOUR MIN. <b>945 P</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-8-1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>98</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>PRINCE GEO Co.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRESIDENTIAL WOODS HEALTH CENTER HOME MAKER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>PRINCE GEO Co</b>		13c. CITY OR TOWN <b>COLLEGE PK.</b>	
14. FATHER'S NAME <b>GEORGE G. WEBB</b>		15. MOTHER'S MAIDEN NAME <b>KATHERINE REISENWEBBER</b>		16. SOCIAL SECURITY NO. <b>220-46-6764</b>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		17b. SOCIAL SECURITY NO. <b>220-46-6764</b>		17c. INFORMANT <b>Mr. Gordon F. Heim - 7103 Stead Court 20782 Hyattsville Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATRIAL FIBRILLATION</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>CARCINOMA OF COLON WITH METASTASIS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-13-87</b> to <b>11-22-87</b> , that (I) (we) lost saw the deceased alive on <b>11-15-87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>V.P. Singh</b>		DEGREE <b>ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR PHYSICIAN</b>		22c. DATE SIGNED <b>11.22.87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V.P. SINGH</b>		22e. ADDRESS <b>5632 ANNAPOLIS RD #9 BLADENSBURG MD. 2071-</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>NOV. 25, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>		23f. REGISTRAR'S SIGNATURE <b>Julia Davidson-Padua</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>HARTLEY MILLER 7527 HARTFORD RD 21234</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



072422 NOV 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	7a. DATE KNOWN OF DEATH		8. MONTH	DAY	YEAR	2b. HOUR		
		Frances Elizabeth Henderson					11-14-87		11	14	87	AM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		8. MONTH	DAY	YEAR	2d. HOUR
Female	White	7-13-53		34 YRS.					11-14-87		11	14	87	AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.
Washington DC		USA				Prince George								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY								
Clinton		Southern Maryland Hospital		Homemaker										
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland		Pr Geo		Camp Springs		YES <input type="checkbox"/> NO <input type="checkbox"/>		4700 Jean Marie Drive						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
Frank		Mary												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No		217 60 7359		John R. Henderson		Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Obesity</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?										
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED								
Augusto P. Rodriguez		Deputy				11-15-87								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS												
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct, Temple Hills, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY TOWN COUNTY STATE								
Burial		18Nov1987		Cedar Hill Cemetery		Suitland Maryland								
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
Robert E Wilhelm Funeral Home		NOV 18 1987		Julia Davidson-Rodriguez										
Suitland Maryland														

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PHA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL OF REMAINS.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

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France - 175423 101011

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show only injury, or other traumatic event; the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
1 DECEASED NAME FIRST MIDDLE LAST		NOV 07 1987		3:42am	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Md.		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcom Grove Hospital, Andrews AFB		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Manager	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md. 13b COUNTY PG		13c CITY OR TOWN Hillcrest Hgts		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Philllip HICKS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Woods		13e STREET ADDRESS / ZIP CODE 2126 Catskill Street 20748	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO. 419-40-3602		17 INFORMANT ADDRESS Mrs. Martha Hicks/wife/same as 13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MULTISYSTEM FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) DISSEMINATED CARCINOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 OCT 19 87, to 07 NOV 19 87, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 07 NOV 19 87, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) NOT view the body after death.					
21a SIGNATURE		DEGREE		22c DATE SIGNED	
EDWARD W. KOLAR, CAPT, USAF MC		MG USAF MC, ANDREWS AFB, MD.,		07 NOV 1987	
21b PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
EDWARD W. KOLAR, CAPT, USAF MC		MG USAF MC, ANDREWS AFB, MD., 20331-5300			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11-13-87		23c NAME OF CEMETERY OR CREMATORY Arlington National	
24 FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E., D.C. 20011		23d LOCATION CITY OR TOWN Ft. Myer, Va.		23e COUNTY Va. STATE	
25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		25c REGISTRAR'S SIGNATURE	
NOV 13 1987		John T. Rhines		John T. Rhines	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE HICKS		2a. DATE OF DEATH MONTH DAY YEAR 11 02 87		2b. HOUR 7 21 A <sub>M</sub>	
3 SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 07 04 06		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO.		13c. CITY OR TOWN FAIRMONT HGTs	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES HICKS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATSY HICKS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS CLARA HICKS (WIFE) 1001 58 <sup>th</sup> AVE FAIRMONT HGTs MARYLAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Prostate Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH <u>24 hrs</u> <u>6 months</u> <u>2 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from <u>13 July 19 87</u> to <u>2 Aug 19 87</u> , that (b) (we) last saw the deceased alive on <u>13 July 19 87</u> , and that in (b) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thomas A. Bensinger</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/2/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BENNINGER		22e. ADDRESS 7525 GREENWAY CIR Dr. Greenbelt MD 20720		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-7-87		23c. NAME OF CEMETERY OR CREMATORY MARYLAND NATIONAL LAUREL P.G. MD.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Julia Benison-Randall	
24. FUNERAL DIRECTOR NAME HOEFMAN FUNERAL SERV. 3605 14 <sup>th</sup> ST N.W.		ADDRESS WASH. D.C.		25a. DATE REC'D. BY REGISTRAR NOV 9 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 above, injury, or other traumatic event, the medical examiner must be notified at a

71341 NOV 1961



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 1. FOR  
 STATE  
 REGISTRAR

 DECEASED NAME  
 (TYPE OR PRINT)

 JOSEPH CLEVELAND HIGGS  
 JOSEPH HIGGS

 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
 11 29 87 5:52 PM

 3. SEX  
 Male

 4. RACE  
 Caucasian

 5. DATE OF BIRTH  
 MONTH DAY YEAR  
 11-23-1936

 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 51 MONTHS DAYS HOURS MIN.  
 YRS.

 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
 Wash., DC

 7b. CITIZEN OF WHAT COUNTRY?  
 USA

 8. MARRIED ☒ NEVER MARRIED ☐  
 WIDOWED ☐ DIVORCED ☐

 9. BALTIMORE CITY OR COUNTY OF DEATH  
 PRINCE GEORGES MD

 10. CITY OR TOWN OF DEATH  
 CLINTON

 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
 (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
 Southern Md Hospital

 12a. USUAL OCCUPATION  
 (TYPE OF WORK FOR MOST OF WORKING LIFE)  
 Butcher

 12b. KIND OF BUSINESS OR INDUSTRY  
 Whsl Meat

 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  
 Maryland Charles Waldorf

 13d. INSIDE CITY LIMITS?  
 YES ☐ NO ☒

 13e. STREET ADDRESS / ZIP CODE  
 207 Briar Wood Place/20601

 14. FATHER'S NAME  
 FIRST MIDDLE LAST  
 Frederick Cleveland Higgs

 15. MOTHER'S MAIDEN NAME  
 FIRST MIDDLE LAST  
 Mary Katherine Vanwert

 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
 yes 1954-1957

 16b. SOCIAL SECURITY NO.  
 215-38-8923

 17. INFORMANT ADDRESS  
 Joanne Higgs - same as # 13

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary artery

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
 2 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) massive a-v. shredding

1 L

DUE TO, OR AS A CONSEQUENCE OF

(c) terminal liver cirrhosis

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Severe coronary artery disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
 YES ☐ NO ☐
 21a. ACCIDENT WAS UNDERLYING ☐  
 OR CONTRIBUTING ☐ CAUSE OF DEATH  
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

 21b. TIME OF INJURY  
 HOUR A.M. MONTH DAY YEAR  
 P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

 WHILE ☐ NOT WHILE ☐  
 AT WORK AT WORK

 21e. PLACE OF INJURY  
 (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION  
 STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/13, 1987, to 11/29, 1987, that (I) (we) last saw the deceased alive on 11/28, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

 ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/30/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

CARLOS ALBERTO M

22e. ADDRESS

2902 St. Bernard Ave. Clarks md 21113

 23a. BURIAL, CREMATION, REMOVAL  
 (SPECIFY)

Burial

23b. DATE

12-3-87

23c. NAME OF CEMETERY OR CREMATORY

Maryland Veterans

23d. LOCATION

Cheltenham Pr. Geo. Md.

24. FUNERAL DIRECTOR

 NAME ADDRESS  
 Hunt Funeral Home Waldorf, Md. 20601

 25a. DATE REGISTERED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
 DEC 02 1987

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, or medical condition, it must be notified at once.

1360.1-3M



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY TERESA HIGGS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11/9/87</b>				2b. HOUR <b>6:29 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01-30-1914</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		IF UNDER 24 HRS HOURS MIN. <b>6:29 P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co MD</b>					
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Aide</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>County Schl</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>373 Accokeek Rd./20601</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard Norris</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leila Hayden</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT ADDRESS <b>J. Leonard Higgs/same as # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ATHEROSCLEROTIC Cardiovasc. Dis</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/2</b> , 19 <b>87</b> , to <b>11/9</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/9</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William D. B. B.</b>								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/10/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. B. B.</b>								22e. ADDRESS <b>3611 Banner Ave. MD 20748</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-12-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Ch. Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Piscataway Pr. Geo., Md.</b>			
24. FUNERAL DIRECTOR Name Address <b>Hunt Funeral Home P. O. Box 156 Waldorf, Md. 20601</b>								25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>			
								25b. REGISTRAR'S SIGNATURE <b>Julia Swiden-Randall</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies; Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

071216 MAY 1967

RECEIVED  
OFFICE OF THE  
DIRECTOR  
MAY 1967

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several paragraphs of text, some of which may be headings or subheadings, but the specific content cannot be discerned.]



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NOV 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>William</u> <u>H</u> <u>HILL, JR.</u>				2a. DATE OF DEATH MONTH <u>11</u> DAY <u>22</u> YEAR <u>87</u>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <u>MARCH</u> DAY <u>15</u> YEAR <u>1937</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>50</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>PRINCE GEORGES</u> <u>MD.</u>	
10. CITY OR TOWN OF DEATH <u>elinton</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SOUTHERN MARYLAND HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>BARBER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HAIR</u>	
13a. STATE <u>MD.</u>				13b. CITY OR TOWN <u>CHARLES WARDORF</u>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>WILLIAM</u> MIDDLE <u>HAVERMAN</u> LAST <u>HILL, SR.</u>				15. MOTHER'S MAIDEN NAME FIRST <u>TERESA</u> MIDDLE <u>GOODE</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>217-34-2448</u>		17. INFORMANT ADDRESS <u>FLORENCE HILL, SAME AS 13E.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rectal cancer with metastases to lungs, liver, and brain</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 6 mos</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21-87</u> to <u>Nov 87</u> , that (I) (we) lost saw the deceased alive on <u>11-21-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>K.Y. Yeung, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-23-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>K.Y. Yeung, M.D.</u>				22e. ADDRESS <u>8926 Woodyard Rd #201 Clinton, MD 20735</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>11-25-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHARLES MEMORIAL</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>GDNS, LEONARDTOWN, STM., MD.</u>	
24. FUNERAL DIRECTOR NAME <u>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 25 1987</u>		25b. SIGNATURE <u>Julia Benson-Randall</u>	

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NOV 27 1987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
HELEN J. HINNANT  
2a DATE OF DEATH MONTH DAY YEAR 2b HOUR MIN  
11 18 87 10 40 AM3 SEX FEMALE 4 RACE WHITE 5 DATE OF BIRTH MONTH DAY YEAR  
AUG. 1, 1929 6 AGE (IN YEARS LAST BIRTHDAY) 58  
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA. 7b CITIZEN OF WHAT COUNTRY? U.S.A.  
8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.10 CITY OR TOWN OF DEATH CHEVERLY 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER  
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY 12b KIND OF BUSINESS OR INDUSTRY P.G. CO. SCHOOLSUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a STATE Md. 13b COUNTY P.G.C. 13c CITY OR TOWN UNIVERSITY PK. YES ☒ NO ☐  
13d INSIDE CITY LIMITS? 13e STREET ADDRESS / ZIP CODE 6502 BALTIMORE AVE. 20782

14 FATHER'S NAME FIRST MIDDLE LAST HANSON FLESHER 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDA PHILLIPS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b SOCIAL SECURITY NO. 578-36-9575 17 INFORMANT ADDRESS HARVEY HINNANT SAME AS ITEM #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Colon with metastases  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 1973, 1973, to 11-18, 1987, that (I) (we) lost saw the deceased alive on 11-17, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE S. C. Gupta DEGREE 22c. DATE SIGNED NOV. 19, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.C. Gupta MD 22e ADDRESS 3503 Perry St. mt. Rainier MD 20912

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE 11-21-1987 23c NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY 23d LOCATION CITY OR TOWN COUNTY STATE CLINTON, P.G.C. Md.

24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. ADDRESS RIVERDALE, Md. 20737 25a DATE REC'D. BY REGISTRAR NOV 25 1987 25b REGISTRAR'S SIGNATURE Julia Anderson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



7 3 6 3 2 DEC -2 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 3 4 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
Geraldine V. Jackson		Hogan						11-23		19		87					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Black	Dec. 25, 1932		54 YRS.						11-23		19		87		230	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Md.		U.S.A.						Prince George's									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Upper Marlboro		9360 D'Arcy Road		Maid		Domestic											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		P.G. Upper Marlboro				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9360 D'Arcy Rd.								20772	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Mary		Jackson		Matthews											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		219-94-1693		Matthew Hogan-Same as # 13 above													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>Hypertensive cardiovascular disease</u> DUE TO OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (c) stating the under- lying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		M.D. <u>Augusto P. Rodriguez, M.D.</u>		MEDICAL EXAMINER		DATE SIGNED <u>11-23-87</u>											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		5009 Rayburn Ct, Temple Hills, MD													
24. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
		11/28/87		ST. LUKE'S CEM.		UPPER MARLBORO, MD											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
H. S. WASHINGTON + SONS		4925 BURROUGHS Ave, N.E.		DEC 01 1987		Julia...											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM-PW-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

3003-10-001

2028 FOLLOW-UP

073797 DEC -3-87

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Hannah Elizabeth HOLBROOK  
2a. DATE OF DEATH MONTH DAY YEAR  
November 29 1987  
2b. HOUR  
4:19a<sub>M</sub>3. SEX  
Female  
4. RACE  
White  
5. DATE OF BIRTH MONTH DAY YEAR  
August 20, 1910  
6. AGE (IN YEARS LAST BIRTHDAY)  
77  
IF UNDER 1 YEAR MONTHS DAYS  
IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Virginia  
7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.  
8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐  
9. BALTIMORE CITY OR COUNTY OF DEATH  
Prince George's MD.10. CITY OR TOWN OF DEATH  
Lanham  
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
AMI Doctor's Hospital  
12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Owner  
12b. KIND OF BUSINESS OR INDUSTRY  
Home ImprovementUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE  
Maryland  
13b. COUNTY  
P.G.  
13c. CITY OR TOWN  
Mt. Rainier  
13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐  
13e. STREET ADDRESS / ZIP CODE  
4005 35th Street 2071214. FATHER'S NAME FIRST MIDDLE LAST  
J. Edgar Richard  
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Annie Lockhart16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)  
No  
16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)  
220-12-2545  
17. INFORMANT (Daughter) ADDRESS  
Catherine D. Fuller Washington, D.C. 2002418. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cardiac arrest  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Acute Myocardial Infarction  
DUE TO, OR AS A CONSEQUENCE OF  
(c) Coronary Atherosclerosis  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
1 hr.  
1 dayPART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Myocardial infarction19a. DATE OF OPERATION  
11/29  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
19c. AUTOPSY?  
YES ☐ NO ☐  
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART I OR PART 2)21d. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
21f. LOCATION STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from 11/29, 19 87, to 11/29, 19 87, that (I) (we) last saw the deceased alive on 11/29, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.22b. SIGNATURE  
Jack C. Meshel  
DEGREE  
MD  
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐  
22c. DATE SIGNED  
11/29/8722d. PHYSICIAN'S NAME (TYPE OR PRINT)  
JACK C. Meshel  
22e. ADDRESS  
5806 Baltimore Ave. Hyattsville Md 2078123a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial  
23b. DATE  
12/01/87  
23c. NAME OF CEMETERY OR CREMATORY  
Fort Lincoln Cemetery  
23d. LOCATION CITY OR TOWN COUNTY STATE  
Brentwood P.G. Maryland24. FUNERAL DIRECTOR  
Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue Hyattsville, Md. 20781  
25. DATE RECEIVED BY REGISTRAR  
DEC 2 1987  
26. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE-MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages retained should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one.

BP

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "TABLE" and "ITEM" are faintly visible.]*

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 17, PAGE 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE		HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
Grace R. Hollweck		11-9 1987			
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Female	White	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS DAYS	HOURS MIN
		9 12 15	72		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
New Jersey	USA	WIDOWED	DIVORCED	Prince George MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Temple Hills	4015 Lyons Street	Retired Secretary		School	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES X NO		4015 Lyons St. 20748	
Maryland Pr. George Temple Hills					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
John Garruti		Mary Jacobs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		139-05-0827		City, Utah	
				Frances DeLong 3715 Astro Way Salt Lake	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE					
DUE TO, OR AS A CONSEQUENCE OF					
Arteriosclerotic cerebro-cardiovascular disease					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES NO X
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner					
Actual Signature August P. Rodriguez M.D. Deputy MEDICAL EXAMINER					
TITLE (SPECIFY) DATE SIGNED 11-12-87					
EXAMINER'S NAME (TYPE OR PRINT) August P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		11/16/87		Calvary Cemetery	
23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Collingswood N.J.		NOV 16 1987		Davidson-Randall	
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate and page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. DECEASED NAME				2a. DATE OF DEATH				2b. HOUR							
FIRST MIDDLE LAST				MONTH DAY YEAR				MONTH DAY HOURS MIN.							
HATTIE L. HOWARD				Nov 24-87				4:30 AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
FEMALE		CAUC.		MAR 31 1961		86 YRS.		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
N.Y.		USA				P.G. County MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Laurel				Greater Laurel Nsg. Home				Income Controller				Shorham Hotel			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Md.		P.G.		Hyattsville				6513 Parkway Ct. 20782							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
Claude R. Palmer				Leo - Claudia Brooks											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				578-07-6329				Frances Reising				20705 Nevis Dr. Beltsville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
<u>Diabetes mellitus</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 86, to present 19, that (I) (we) lost saw the deceased alive on 11/14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
LUIS A CABAS MD				8317 CITERA LA LAUREL MD 20707											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				11/27/87		Arlington Natl. Cemetery				Arlington Fairfax Virginia					
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Donald V. Borgwardt 4400 Powder Mill Rd Beltsville Md 20705												NOV 30 1987		Julia Gordon-Randall	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 3 3 4 6

91-2272405

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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

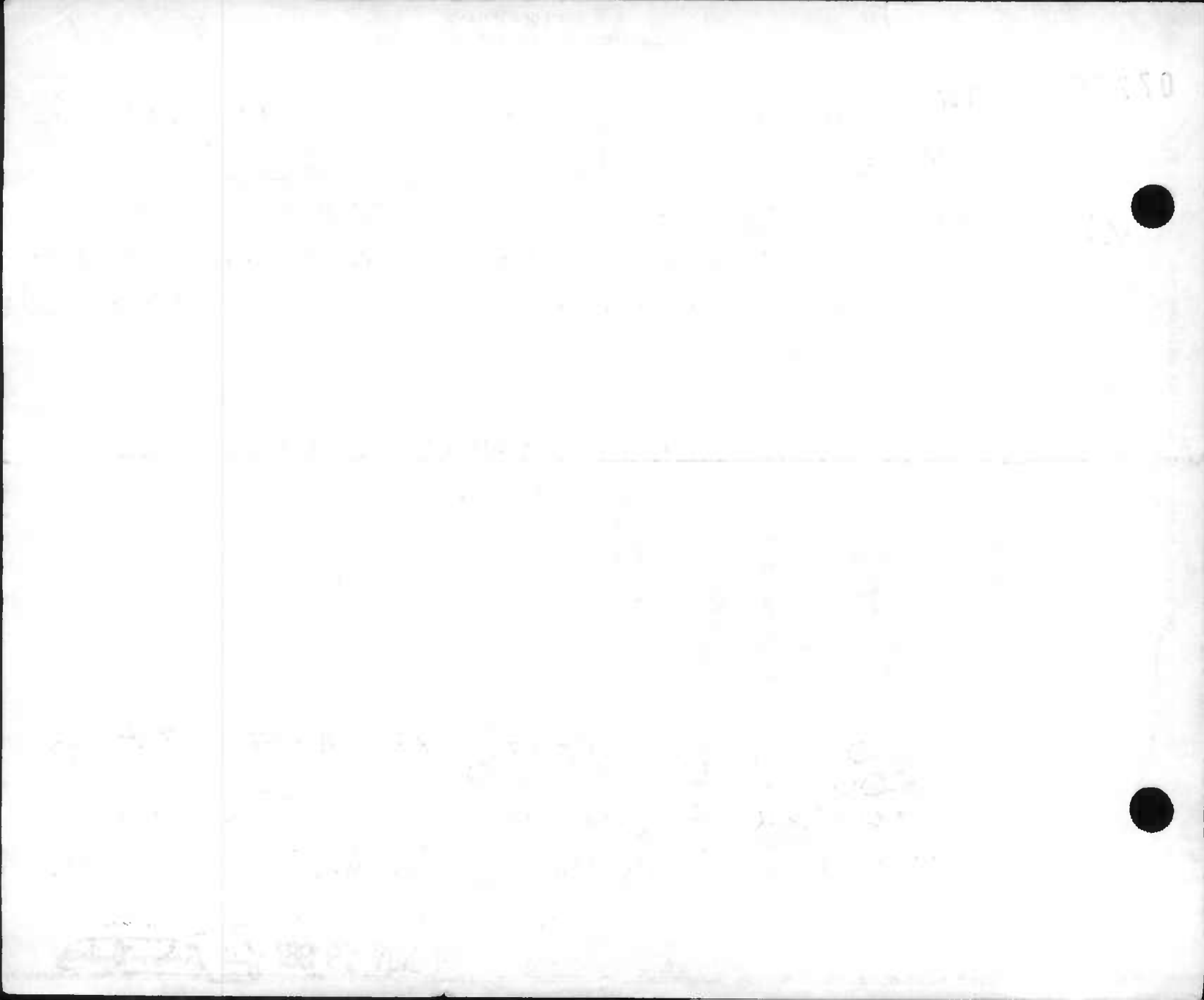
1. DECEASED NAME (SUGGESTED) FIRST Harold MIDDLE Jack LAST Hudson, Jr. <b>HAROLD Jack HUDSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/14/87</b>		2b. HOUR <b>4:00 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 20, 1946</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>		10. CITY OR TOWN OF DEATH <b>Fort Washington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8319 Bella Vista Terrace</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PHYSICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private Practice</b>		13. STREET ADDRESS / ZIP CODE <b>8319 Bella Vista Terrace / 20744</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harold Jack Hudson, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jeann Head</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
17. INFORMANT ADDRESS <b>James E. Woods, Same as 13</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMOCYSTIS CARINII PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACQUIRED IMMUNODEFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11-14 1987 to 11-14 1987</b>		22a. I certify that (1) (this hospital) attended the deceased from <b>11-14 1987</b> , and that (2) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Michael F. York MD</b> DEGREE <b>HOSPICE</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED <b>11-15-87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL F. YORK MD</b>		22e. ADDRESS <b>5506 GREEN LANDING RD UPPER MARLBORO MD 20772</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-16-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>		24. FUNERAL DIRECTOR NAME <b>Richard Rapp, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Anderson</b>		25c. ADDRESS <b>P. O. Box 43352, Washington, DC 20010</b>			

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be evaluated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate of page 3 and file it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.



071522 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Medical examiner must be notified at once if death is sudden or unexpected. If item 21 is marked or item 18 shows any injury, or other traumatic evidence, medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR2. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

GEORGE

Lee

HUSTON

3. DATE OF DEATH

MONTH

DAY

YEAR

11 05 87

2b. HOUR

1 55PM

3. SEX

Male

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH

DAY

YEAR

12 29 44

6. AGE (IN YEARS LAST BIRTHDAY)

42

IF UNDER 1 YEAR

MONTHS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S

MD

10. CITY OR TOWN OF DEATH

CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

PRINCE GEORGE'S HOSPITAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Painter

12b. KIND OF BUSINESS OR INDUSTRY

Various Jobs

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Prince Geo.

13c. CITY OR TOWN Edmondston

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4903 47th Avenue

20781

14. FATHER'S NAME

Unavailable

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

Virginia

MIDDLE

Huston

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

214-42-7140

17. INFORMANT

ADDRESS

Annie Huston (wife) Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Renal Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Low

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Acute Hepatitis, cardiomyopathy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (his hospital) attended the deceased from 11/5 to 11/5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/6/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Don H. Yablonski

22e. ADDRESS

10300 Greenbelt Rd Suite 101 Secbrook, MD 20706

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11/10/87

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Brentwood Prince Geo. MD

24. FUNERAL DIRECTOR

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Ave. Hyattsville, MD 20781

25a. DATE REC'D. BY REGISTRAR

NOV 10 1987

25b. REGISTRAR'S SIGNATURE

- Gordon P. Pender

01 1251 1351 70

0730'49 NOV 25 '87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

3 3 3 4 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRY Dayton IDEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 17 1987</b>		2b. HOUR <b>12 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 20 1895</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Champion E. Iden</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Bohrer</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes-Army</b>		16b. SOCIAL SECURITY NO. <b>W.W.I 578-46-6774</b>		17. INFORMANT (Daughter) <b>Kathryn Irene Iden</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>		DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>PNEUMONIA</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/16/87 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10/4/87</b> to <b>10/16/87</b> , that (I) (we) last saw the deceased alive on <b>10/16/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>A. DASHOTTA</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. DASHOTTA MD</b>		22e. ADDRESS <b>5632 Annapolis Rd. #7 Bladensburg, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cem. Adelphi P.G. Maryland</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Francis Gasch's Sons Funeral Home, P.A.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>				
23f. REGISTRAR'S SIGNATURE <b>Julia Davidson-Lindner</b>		23g. ADDRESS <b>4739 Baltimore Avenue Hyattsville, Md. 20781</b>				

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

01-30-10-10

W. 100

100 PS VON



073676 DEC

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

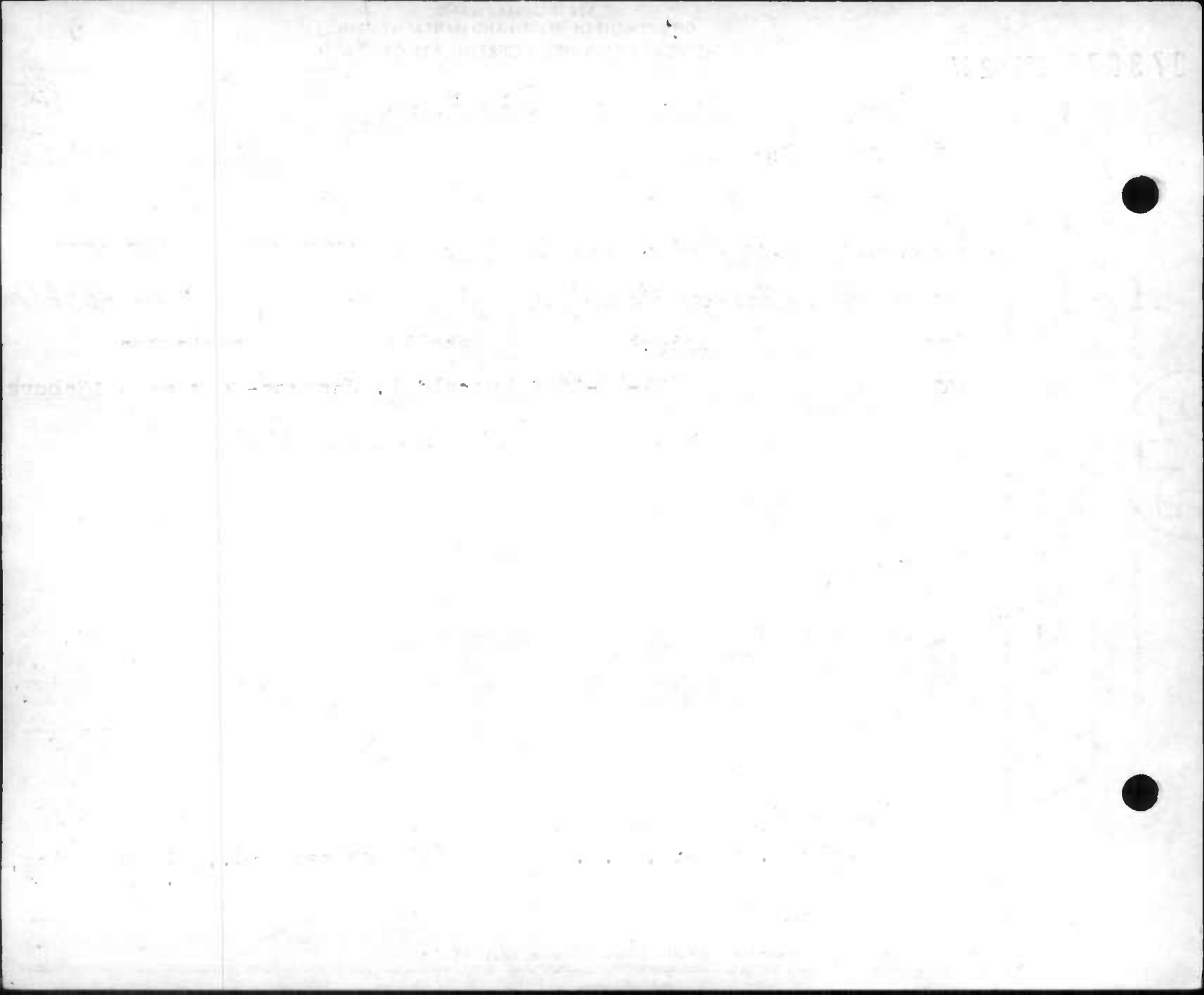
REG. NO.

33350

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Earline Wright Jackson</i>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>Nov 22 1987</i>			2b. DATE ESTIMATED MONTH DAY YEAR <i>Nov 22 1987</i>			
3. SEX <i>F</i>	4. RACE <i>Blk</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 11 39</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) <i>55</i> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Nov 22 1987</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD.</i>			
10. CITY OR TOWN OF DEATH <i>Adelphi</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1804 Metzer Cr. Rd. Apt 203</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD</i> COUNTY <i>Prince Georges</i> CITY OR TOWN <i>Adelphi</i>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <i>1804 Metzer Cr. Rd. Apt 203</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lee Wright</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Estelle Washington</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>579-46-3095</i>		17. INFORMANT ADDRESS <i>Gerald L. Jackson-Same as # 13 above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>									
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. <i>MD</i>			DATE <i>11/30/87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>			ADDRESS <i>1919 Seminary Rd., Silver Spring, MD.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>11/30/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CHELTENHAM VETS CEM. CHELTENHAM MD.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>H. S. WASHINGTON &amp; SONS</i>			ADDRESS <i>4925 BURROUGHS AVENUE</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 01 1987</i>			
						25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. FOR YOUR FILES, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



072582 NOV 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS B JACKSON					2a. DATE OF DEATH MONTH DAY YEAR 11 04 87			2b. HOUR 1 41P M		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 03 03 11		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker Own Home		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY P.G.		13c. CITY OR TOWN Glenn Dale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Webster					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Plater					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-34-3564		17. INFORMANT ADDRESS Andre Jackson-1910 Bowie, Md. Arbor Hill Ln.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Severe Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Aortic Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Emphysema congestive Heart Failure</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11-4-87</u> , 19____, to <u>11-4-87</u> , 19____, that (I) (we) lost saw the deceased alive on <u>11-4-87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Hyado MD</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/5/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YADLA				22e. ADDRESS 577-8811		22f. ADDRESS 9470 ANNAPOLIS Rd 2 ANNHAM 20706				
23a. BURIAL CREMATION, REMOVAL (SPECIFY)		23b. DATE 11/9/87		23c. NAME OF CEMETERY OR CREMATORY GLENN DALE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE GLENN DALE P.G. MD.				
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON					25a. DATE REC'D. BY REGISTRAR NOV 19 1987					
25b. REGISTRAR'S SIGNATURE Davidson-Randall										

045201 135

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME

FIRST

MIDDLE

Last Jacoby

Lena

B.

Jacoby

2a. DATE OF DEATH

MONTH

DAY

YEAR

11-03-87

2b. HOUR

5:35am

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

June 21, 1903

6. AGE (IN YEARS LAST BIRTHDAY)

84

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges CO, MD

10. CITY OR TOWN OF DEATH

Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Southern Md. Hospital

12a. USUAL OCCUPATION

Statistical Steno

12b. KIND OF BUSINESS OR INDUSTRY

Southern RR

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Charles

13c. CITY OR TOWN

LaPlata

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

RR4 Box 4151

20646

14. FATHER'S NAME

Herman

MIDDLE

LAST

Behrens

15. MOTHER'S MAIDEN NAME

Emilie

MIDDLE

D.

LAST

Kattenberg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

N/A

17. INFORMANT

579-22-0210

17. INFORMANT

Joseph Belfield

ADDRESS

Same as 13 A-E

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) ARRY

DUE TO, OR AS A CONSEQUENCE OF

(c) MASSIVE SEPSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MALNUTRITION &amp; HYPOALBUMINEMIA &amp; RENAL DYSFUNCTION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/11/87 to 11/2/87, that (I) (we) last

saw the deceased alive on 8/11/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Annette Gonsalves

DEGREE

ATTENDING

PHYSICIAN ☒

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☐

22c. DATE SIGNED

11/3/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Annette Gonsalves

22e. ADDRESS

60 Post office Rd. #100 md. 20601

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY) Cremation

23b. DATE

11/04/87

23c. NAME OF CEMETERY OR CREMATORY

Lee's Crematory

23d. LOCATION

Clinton

23e. ADDRESS

Prince Geo. Md.

24. FUNERAL DIRECTOR

NAME

Lee Funeral Home, Inc.

ADDRESS

Old Alexander Ferry Rd. Clinton, Md 20735

25a. DATE REC'D. BY REGISTRAR

NOV 04 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

071025 NOV-98



074568 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Albert Johnson</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>11/25/87</u>			2b. HOUR-AM <u>7:12</u> AM		
3. SEX <u>M</u>		4. RACE <u>Neam</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>4/19/20</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>PRINCE GEORGES MD.</u>					
10. CITY OR TOWN OF DEATH <u>Forestville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Regency Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Equipment Oper.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>VIRGINIA</u> 13b. COUNTY <u>Westmoreland</u> 13c. CITY OR TOWN <u>Montross</u>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>RT 2, Box 584 99999</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>UNKNOWN</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>JOHNSON</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>223-204599</u>		17. INFORMANT <u>DARLENE JOHNSON</u>		ADDRESS <u>RT 2 Box 584</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>DEMENTIA</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11 20</u> , 19 <u>87</u> to <u>11 25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11 23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>William Kent Furst</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/25/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WILLIAM K. FURST</u>						22e. ADDRESS <u>11801 Livingston RD. Ft. Washington, PA</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>11-28-1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SILK OAK CHURCH</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>MONTROSS VIRGINIA</u>					
24. FUNERAL DIRECTOR NAME <u>WELDON FUNERAL HOME</u>						ADDRESS <u>OLD HAMS, VA</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC - 8 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Lisa Anderson</u>	

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071417 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BEATRICE G. JOHNSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 2, 1987</b>		2b. HOUR <b>3:40P M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 14, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES CO. MD</b>	
10. CITY OR TOWN OF DEATH <b>BELTSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11421 EMACK RD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. STATE <b>Md.</b>	13b. COUNTY <b>P.G.C.</b>	13c. CITY OR TOWN <b>BELTSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>11421 EMACK RD. 20705</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LUTHER GOLDEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GLADYS BURTON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-12-2613</b>		17. INFORMANT ADDRESS <b>ALBERT J. JOHNSON (SAME AS ITEM #13)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic cancer of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October 6, 1980</u> to <u>Nov 2, 1987</u> , that (I) (we) last saw the deceased alive on <u>October 19, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Martin D. Weitzer</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>11/2/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Martin D. Weitzer, D.O.</u>		22e. ADDRESS <u>7525 Greenway Ctr. Dr. Greenbelt, Md. 20770</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>11-5-1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD, P.G.C. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO.</b>		ADDRESS <b>RIVERDALE, Md. 20737</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1987</b>	
		25b. REGISTRAR'S SIGNATURE <u>John E. Ridenour</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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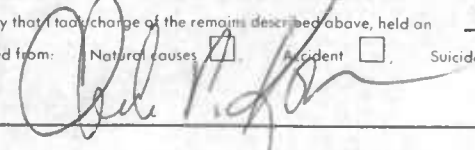

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MW 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										33355	
FOR ITEM 8, 117& FILM G68										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLOTTE M. JOHNSON</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11-23-87</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 25, 1932 55 YRS.</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>55 YRS.</b>		7c. DATE PRONOUNCED DEAD <b>11-23-87</b>		2b. HOUR <b>6:15p</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Accokeek</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>17012 Livingston Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foster Parent</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Ft. Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>17012 Livingston Rd. 20744</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Unk. Green</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanora Unk. Belt</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT <b>Husband</b>			ADDRESS <b>413 GRAY VINE LA SON-MARK JOHNSON, MITCHELLVILLE, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt head injuries and multiple stab wounds</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 11-23-87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>subject beaten and stabbed</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>residence</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>17012 Livingston Road Accokeek, Maryland</b>					
22a. I certify that I took charge of the remains described above, held on <b>Autopsy <input checked="" type="checkbox"/></b> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11-24-87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles P. Kokes, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Pope, Alexander s.</b>						ADDRESS <b>2617 Pa. Ave. S.E.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE 	

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073447 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN REMARKS, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT - PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR <u>Number/ Gbj.</u>										33356	
DECEASED NAME (TYPE OR PRINT) <b>Ernest W. Johnson</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/ 22/ 19 87</b>	
2b. HOUR <b>5:17 P</b>											
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 7 62</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>11/ 22/ 19 87</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>					
10. CITY OR TOWN OF DEATH <b>Camp Springs</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Andrew's Airforce Base - MCMC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Porter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Value Village Thrift Store</b>			
13a. STATE <b>D. C.</b>		13b. COUNTY <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4605 5th Street, N.W.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Maurice Johnson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Joann Johnson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-90-4495</b>		17. INFORMANT ADDRESS <b>Mrs. Joann T. Gibson/mother/7910 14th Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ <b>Gunshot Wound of Chest (unspecified) Langley Park, Md.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>4:00</b> MONTH DAY YEAR <b>11/ 22/ 19 87</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>				21f. LOCATION CITY OR TOWN COUNTY STATE <b>2110 Brooks Dr., Forestville, Pr. Geo., Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER DATE SIGNED <b>11/23/87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>11-28-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John T. Rhines Co., 3015 12th St. N.E., D.C. 20001</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Swenson-Randall</i>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Juanita W. Johnson			2a. DATE OF DEATH MONTH DAY YEAR November 11 1987			2b. HOUR 12:27p <sub>M</sub>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 18, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital of Pr. Geo				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Co. HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY P.G.C.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES M. WINSTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA P. EZELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 216-10-6792A		17. INFORMANT ADDRESS BERNARD N. JOHNSON (SAME AS ITEM #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>43 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Bacterial Endocarditis, sepsis, Renal failure, Fungemia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September 30, 1987</u> to <u>November 11, 1987</u> , that (I) (we) last saw the deceased alive on <u>November 11, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>CHIN-CHUAN Hsu</u>				DEGREE M.D.		22c. DATE SIGNED NOV. 12, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHIN-CHUAN Hsu</u>				22e. ADDRESS <u>419 Baltimore Avenue Riverdale Maryland 20737</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-16-1987		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD, P.G.C., Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR NOV 16 1987	
				25b. REGISTRAR'S SIGNATURE <u>David R. Rando</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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ST. LOUIS, MO. 1000  
U.S. DEPT. OF COMMERCE  
BUREAU OF ECONOMIC ANALYSIS  
WASHINGTON, D.C. 20540  
NOV 17 1961  
TO: DIRECTOR, BUREAU OF ECONOMIC ANALYSIS  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

CHINA CHANG  
NOV 17 1961  
[illegible text]



072439 NOV 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NEZZIE ARDENIA JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 7 1987</b>			2b. HOUR MIN. <b>11:32P</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 28 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AMI DOCTORS' HOSPITAL OF PR. GEO.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CO. Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Greenbelt</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Davis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Ritter</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>Gwendolyn Johnson (daughter) same as item #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <span style="float:right">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u></span> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery Disease</u> <span style="float:right"><u> yrs.</u></span> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Peripheral vascular disease</u> <span style="float:right"><u> yrs.</u></span>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>status Post Bilateral Bk Amputations</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> 19 <u>87</u> to <u>11/7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Surinder Singh</u>				DEGREE		22c. DATE SIGNED <u>11/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SURINDER SINGH</u>				22e. ADDRESS <u>4700 Berwyn Howard College Park, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SEE ITEM 1) <b>Burial</b>		23b. DATE <b>11-14-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Zion Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Robbins, N.C.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Vann &amp; Williams, 4804 Ga. Ave., N.W., Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1987</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Darden-Randall</u>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove endpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WADE O JONES JR			2a. DATE OF DEATH MONTH DAY YEAR 11-28-87			2b. HOUR 12:00 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12-24-1933		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. MARYLAND HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) proof reader: GPO U.S. Govt.	
13a. STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wade Jones, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Horner		13e. STREET ADDRESS / ZIP CODE 3516 Danville Rd. 20613			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW11		17. INFORMANT Sammie D. Jones Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laryngeal cancer with pulmonary metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Urinary bladder cancer, transitional cell carcinoma type							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 19 86 to November 19 87, that (I) (we) last saw the deceased alive on 11-27 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kai-Yin YEUNG, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin YEUNG, MD				22e. ADDRESS 8926 Woodyard Rd # 201 Clinton, MD 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-29-87		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home 6633 Old Alexander Ferry Rd. Clinton, Md.				25a. DATE REC'D. BY REGISTRAR DEC 02 1987		25b. REGISTRAR'S SIGNATURE John E. Swisher-Rendell	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The local registrar must sign this certificate and completely filled in by the funeral director within 72 hours after death. If the local registrar is unavailable, the funeral director may sign this certificate and completely filled in by the funeral director within 72 hours after death. If the funeral director is unavailable, the local registrar may sign this certificate and completely filled in by the funeral director within 72 hours after death.

DHMH - 16 60M 7/84  
(VIA 15, 4) 6633

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joshua Ryan Jordan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Nov 07 87</i>		2b. HOUR <i>4:15 AM</i>	
3. RACE <i>Male</i>		4. RACE <i>Cauc</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 21, 1984</i>		
6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		8. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i>		10. CITY OR TOWN OF DEATH <i>Camp Springs</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Malcolm Grow Hosp. Andrews AFB</i>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N/A</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>		13. STREET ADDRESS / ZIP CODE <i>305 L. Street 88220</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Theodore Jordan</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Claudia Smith</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		
17. SOCIAL SECURITY NO. <i>N/A</i>		18. INFORMANT <i>Theodore Jordan</i>		19. ADDRESS <i>4268-1 Wilmington Dr. AAFB Camp Springs, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Smoke inhalation</i> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Housefire - thermal injury</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8:40 P.M. Nov 07 1987</i>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>House Fire</i>		21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>At home</i>		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>4268-1 Wilmington Drive Andrews AFB Md.</i>		22a. I certify that (I) (this hospital) attended the deceased from <i>11/11/87</i> to <i>11/11/87</i> , that (I) (we) lost saw the deceased alive on <i>11/11/87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>James M. Shelley, M.D.</i>		
22c. DEGREE <i>Chief Pathologist</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James M. Shelley, M.D.</i>		22e. ADDRESS <i>Dept of Path/GH/ Andrews AFB, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (USE PREVIOUS)		23b. DATE <i>11/11/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Carlsbad Cemetery</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Carlsbad Eddy N. M.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Lee Funeral Home, Inc. Old Alexander Ferry Rd Clinton, Md 20735</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 12 1987</i>		
25b. REGISTRAR'S SIGNATURE <i>James Gordon Rudege</i>						

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director within 72 hours after death. If the funeral director is unavailable, the local registrar may sign this certificate and completely filled in by the funeral director within 72 hours after death.

07 NOV 13 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The local registrar must sign this certificate and completely filled in by the funeral director within 72 hours after death. If the local registrar is unavailable, the funeral director may sign this certificate and completely filled in by the funeral director within 72 hours after death. If the funeral director is unavailable, the local registrar may sign this certificate and completely filled in by the funeral director within 72 hours after death.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF ESTI- MATED DEATH			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH					
Sean Terrence Keating			11-19 1987			11-19 1987			11-19 1987			11-19 1987					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7. MARRIED			8. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH					
Male	White	Aug 13, 1965	22	MONTHS	DAYS	WIDOWED	NEVER MARRIED	PRINCE GEORGE	PRINCE GEORGE			PRINCE GEORGE					
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	11. CITIZEN OF WHAT COUNTRY?		12. MARRIED		13. BALTIMORE CITY OR COUNTY OF DEATH		14. BALTIMORE CITY OR COUNTY OF DEATH			15. BALTIMORE CITY OR COUNTY OF DEATH			16. BALTIMORE CITY OR COUNTY OF DEATH				
Washington DC	USA		MARRIED		PRINCE GEORGE		PRINCE GEORGE			PRINCE GEORGE			PRINCE GEORGE				
17. CITY OR TOWN OF DEATH	18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		20. KIND OF BUSINESS OR INDUSTRY		21. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			22. KIND OF BUSINESS OR INDUSTRY			23. KIND OF BUSINESS OR INDUSTRY				
Clinton	P.G. Cty Assoc for retarded		Dependent		N/A		Dependent			N/A			N/A				
24. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												25. CITY OR TOWN			26. STREET ADDRESS		
Maryland Montgomery												Citizens			908 Davis Avenue 20912		
27. FATHER'S NAME			28. MOTHER'S MAIDEN NAME			29. FATHER'S NAME			30. MOTHER'S MAIDEN NAME			31. FATHER'S NAME			32. MOTHER'S MAIDEN NAME		
Terrence O Keating			Priscilla Dunford			Terrence O Keating			Priscilla Dunford			Terrence O Keating			Priscilla Dunford		
33. WAS DECEASED EVER IN U.S. ARMED FORCES?			34. SOCIAL SECURITY NO.			35. INFORMANT			36. ADDRESS			37. ADDRESS			38. ADDRESS		
No			261-91-6366			Priscilla & Terrence Keating			Same as #13			Same as #13			Same as #13		
39. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple Neurologic Congenital Anomalies</i>																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE			DATE			MEDICAL EXAMINER			DATE SIGNED			DATE SIGNED			DATE SIGNED		
Augusto P. Rodriguez			11-20-87			Deputy			11-20-87			11-20-87			11-20-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			ADDRESS			ADDRESS			ADDRESS			ADDRESS		
Augusto P Rodriguez M.D.			5009 Ray burn Court Camp Spgs Md			5009 Ray burn Court Camp Spgs Md			5009 Ray burn Court Camp Spgs Md			5009 Ray burn Court Camp Spgs Md			5009 Ray burn Court Camp Spgs Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			COUNTY			STATE		
Burial			23Nov1987			Washington National			Cemetery Suitland PG			MD			MD		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE			25e. REGISTRAR'S SIGNATURE		
Robert E Wilhelm			NOV 23 1987														
Funeral Home			Suitland, MD.														

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE MUST BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

075003 NEW 24 01

RECEIVED



Handwritten text, possibly a signature or date, appearing as "1947" and "10-10-47".

Handwritten text, possibly a signature or date, appearing as "1947" and "10-10-47".

075003 NEW 24 01



073854 DEC 13 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

B 7 3 3 3 6 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SALLIE E. KEEGAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 23, 1987</b>		2b. HOUR <b>210P<sup>M</sup></b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 25, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>P. G. General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George's</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Pusey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Patience unk.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-10-8812</b>		17. INFORMANT ADDRESS <b>John W. Keegan same as 13e.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOTENSIVE ENCEPHALOPATHY</b>					<b>1 WEEK</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ISCHEMIC CARDIOMYOPATHY</b>					<b>2 MONTH</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>PERFORATED DIVERTICULITIS</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>VESICO VAGINAL COLONIC FISTULA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from 19 <b>70</b> to <b>NOV</b> 19 <b>87</b> , that (1) (we) last saw the deceased alive on <b>NOV 22</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Norman K. Bohner MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>NOV 23, 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Norman K. Bohner</b>		22e. ADDRESS <b>3231 SUPERIOR LANE Bowie MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal/Burial</b>		23b. DATE <b>NOV 28, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Delaware</b>		23e. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>			
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>		16000 Annapolis Road Bowie, MD 20715-3043		25a. REGISTRAR'S SIGNATURE <b>John W. Keegan</b>	

MEDICAL CERTIFICATION

289

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DEC 2 1951

073855 DEC-31

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Evelyn B. Kelleher</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 24, 1987</b>		2b. HOUR <b>12:55P<sub>M</sub></b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>September 7, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AMI Doctors' Hospital of Pr. Geo Co</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Pr. George's</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>12011 Tulip Grove Drive 20715</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mark Bartal</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Teresa Guyer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>018-14-1026</b>		17. INFORMANT <b>Paul H. Kelleher</b> ADDRESS <b>12011 Tulip Grove Drive Bowie, Maryland 20715</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic renal failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>85</u> , to <u>Nov.</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Marc Getka, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>Nov. 25, 1987</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marc Getka, M.D.</b>		22e. ADDRESS <b>14300 Gallant Fox La. Bowie, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>NOV 30, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Silver Spring, Montgomery, MD</b>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>	16000 Annapolis Road Bowie, MD 20715-3043	25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>	25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

*[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]*

072448 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY W. KELLEY			2a. DATE OF DEATH MONTH DAY YEAR 11 12 87		2b. HOUR 10 05PM M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Mar. 4, 1915		
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		10. CITIZEN OF WHAT COUNTRY? USA		11. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
12. CITY OR TOWN OF DEATH CHEVERLY		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland		15b. COUNTY P.G.		15c. CITY OR TOWN Landover		
16. FATHER'S NAME FIRST MIDDLE LAST Henry W. Kelley		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Lavanne		18. STREET ADDRESS / ZIP CODE 1827 Belle Haven Drive 20785		
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		20. SOCIAL SECURITY NO. 577 14 9270		21. INFORMANT ADDRESS Carrie Kelley-wife-1827 Belle Haven Drive, Landover, Maryland		
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>postbaccute myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis - Generalized</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus, Hypertension</u>						
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		23c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
25a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25c. LOCATION STREET CITY OR TOWN COUNTY STATE		
26. I certify that (I) (this hospital) attended the deceased from <u>11-12-87</u> , 19 <u>87</u> , to <u>11-12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
27a. SIGNATURE <u>R. Rustagi</u>		27b. DEGREE MD		27c. DATE SIGNED		
28a. PHYSICIAN'S NAME (TYPE OR PRINT) RAVINDER K. RUSTAGI MD		28b. ADDRESS 6132 Landover Rd Cheverly Md 20785		29. MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		
30a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		30b. DATE Nov. 17, 1987		30c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery Rockville, Md		
31. FUNERAL DIRECTOR NAME Stewart Funeral Home		31b. ADDRESS 4001 Benning Road, N.E.		32. DATE RECEIVED BY REGISTRAR'S SIGNATURE NOV 18 1987		

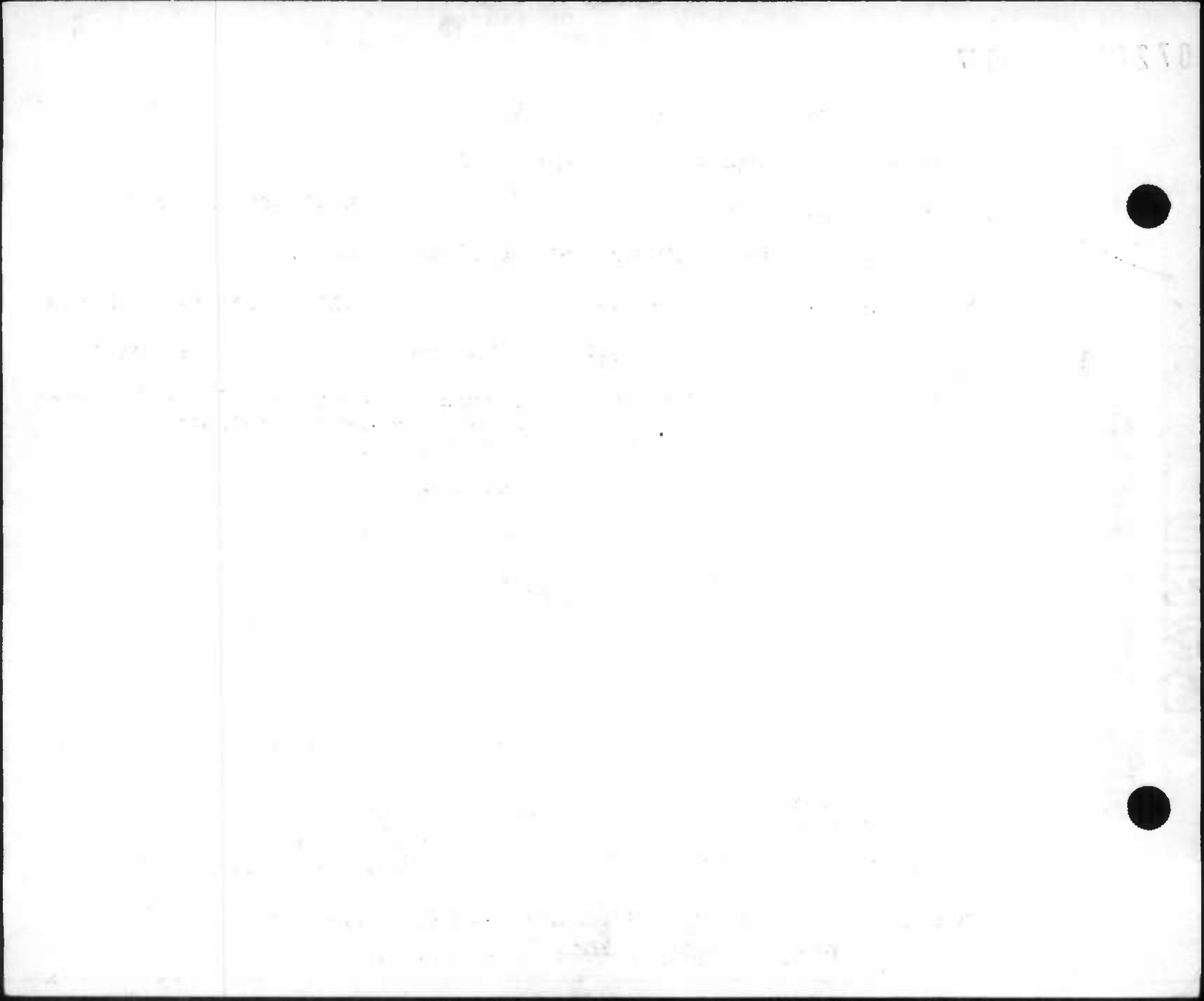
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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071520 NOV 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ATTACH PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR P.M. 3. ATTACH PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST				2b. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR		2b. HOUR
James William Phillip Keys										Nov. 4, 1987		4:46 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR
Male	White	July 18, 1911		76 YRS.						Nov. 4, 1987		4:46 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		U.S.A.						Prince George's County MD.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale				Leland Memorial Hospital				Plumber		Self-Employed		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Prince George's		Hyattsville				5705 43rd Avenue, #1 20781				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
William Leachman Keys				Annie Elizabeth Waite								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No				577-16-9436		5705 43rd Ave. #1 Anna Mae Keys (Wife) Hyattsville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Chronic Myocardial Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE YEARS BETWEEN ONSET AND DEATH 20781		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
None												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
None												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy				DATE SIGNED				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
John S. Rogers, M.D.				1919 Seminary Rd. Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN				
Burial				11/07/87		Woodbine Baptist Church		Prince William Independent Hill Virginia				
24. NAME OF FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Francis Gasch's Sons Funeral Home, P.A.				NOV 10 1987				[Signature]				
4739 Baltimore Avenue Hyattsville, Md. 20781												

071250 NOV 15 11



072451 NOV 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED TO PMD BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate pages. Valid 2 weeks be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ulysses Walter KING SR.			2a. DATE OF DEATH MONTH DAY YEAR November 7, 1987		2b. HOUR 4:05 PM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1926	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR. GEO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CO. Retired	12b. KIND OF BUSINESS OR INDUSTRY Gov	
13a. STATE Maryland			13b. COUNTY PG	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 5011 Baltimore Lane 20706			14. FATHER'S NAME FIRST MIDDLE LAST John J. King		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Lacy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes		
16b. SOCIAL SECURITY NO. 578 38 8477			17. INFORMANT ADDRESS Barbara M. King-wife-5011 Baltimore		

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE PERIOD  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/7/87 to 11/7/87, that (I) (we) last saw the deceased alive on 11/7/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

AROOR RAO, M.D.

22e. ADDRESS

6130 Oxon Hill Rd., #301, Oxon Hill, Md. 20745

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 13, 1987	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION Brentwood, Maryland
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, N.E.		25a. DATE RECEIVED BY REGISTRAR NOV 18 1987	

TO BE VIEWED 12 4 50

10

REG. NO.

FOR  
STATE  
REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

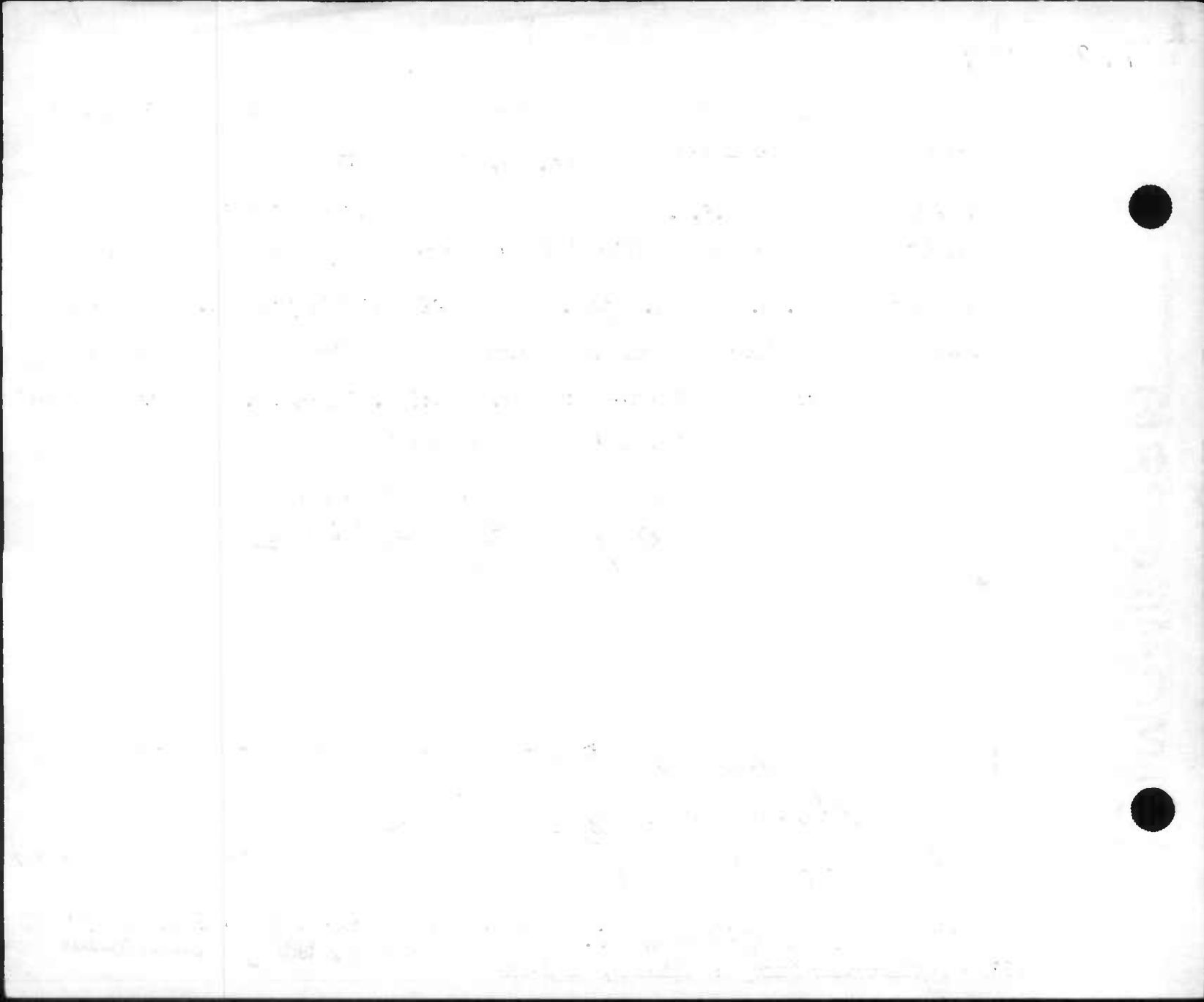
**RETURN TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed with the funeral director. Pages 1 and 2 should be filed with the coroner. **Important:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15.4) 6

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
EDITH		M		KLINE		11 08 87		12:24A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		Aug. 17, 1928		59 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CHEVERLY		PRINCE GEORGE'S HOSPITAL CENTER		Homemaker		Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE		13e. STREET ADDRESS / ZIP CODE	
Maryland		P. G.		Cap. Hgths.		6703 Dry Log St.		20743	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Jesse		Edna		No		577-32-8608		Mr. Edward E. Kline, Sr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myofascia dystrophica</u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Respiratory Failure</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-17</u> , 19 <u>87</u> , to <u>11-08</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/6/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Revathy Muthy</u>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
		22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS		22h. PHYSICIAN'S NAME (TYPE OR PRINT)		22i. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11/12/87		Ft. Lincoln Cemetery		Brentwood Prince George's MD		Brentwood Prince George's MD	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		24d. DATE REC'D BY REGISTRAR		24e. REGISTRAR'S SIGNATURE	
Lee Funeral Home, Inc.		NOV 12 1987		Julia Dunder-Rudner		NOV 12 1987		Julia Dunder-Rudner	
25. OLD ALEXANDER FERRY RD CLINTON, MD 20735		25b. DATE REC'D BY REGISTRAR		25c. REGISTRAR'S SIGNATURE		25d. DATE REC'D BY REGISTRAR		25e. REGISTRAR'S SIGNATURE	



070820 NOV-5 '87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Blanche J Kramer			2a. DATE OF DEATH MONTH DAY YEAR Nov 3 87		2b. HOUR 12:15 AM
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR Dec 8 87		6. AGE (IN YEARS LAST BIRTHDAY) 99	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heater Laurel Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker.		12b. THE KIND OF BUSINESS OR INDUSTRY own home
13a. STATE Maryland			13b. COUNTY Prince Geo.	13c. CITY OR TOWN Glen Dale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Not Available			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 469-07-2739D		17. INFORMANT ADDRESS Eleanor H. Kramer 6501 Highbridge Road Bowie, Maryland 20715	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CHF.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/25/87</u> to <u>11/3/87</u> , that (I) (we) last saw the deceased alive on <u>10/25/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Luis A Casas MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS A CASAS MD		22e. ADDRESS 8317 CHERRY CA LAUREL MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE NOV 5, 1987	23c. NAME OF CEMETERY OR CREMATORY First Luth.Ch.Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bowie, Prince George's, MD
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR NOV 04 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "is", "are" are visible.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETURN THIS FORM TO THE MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE/  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
JOHN Patrick LaBRIOLA						11 02 87					19	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	Caucasian	03/17/17	70			11 02 87					19	9:50 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
New York			U.S.A.						Prince George's MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Clinton			Southern Maryland Hospital Center			District Mgr.			Pepsi Cola			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS
Maryland			P. G.			Brandywine			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9706 Prince Wm. Dr. 20613
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
Frank						LaBriola						Angelina
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
Yes						WWII			116-03-8434			Thelma LaBriola Same as 13 A-E

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. Deputy MEDICAL EXAMINER DATE SIGNED 11/2/1987  
 EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct, Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	11/04/87	Maryland Veterans Cem.	Cheltenham Prince George's MD
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Lee Funeral Home, Inc.		NOV 04 1987	
6633 Old Alexander Ferry Rd Clinton Md 20735		25b. REGISTRAR'S SIGNATURE	
		Julia Davidson-Randall	

051024 HCY-083

1





072257 NOV

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33370

1. DECEASED NAME (PRINT) <b>1887 Ronald Gordon Lange</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11-11 1987</b>		2b. HOUR <b>8765</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01-13-29</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Pest Control</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS <b>5353 Quincy Pl., 20784</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Lange</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mae Elizabeth Cole</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>579-34-6508</b>		17. INFORMANT ADDRESS <b>Joan Lange, Same as Line #13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>11-11-87</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>11-15-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>	
24. FRANK J. GASCH'S SONS FUNERAL HOME, P.A. NAME ADDRESS <b>4739 Baltimore Ave., Hyattsville, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>		
		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodriguez</b>		

DIVISION OF VITAL RECORDS 201 W. PRINCE ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRINCE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (1))

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20% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.

173671 DEC 28 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33371

FOR  
1- STATE  
REGISTRAR2- DECEASED NAME  
(TYPE OR PRINT)

FIRST Jeanette

MIDDLE E.

LAST

Langenegger

2a. DATE OF DEATH MONTH DAY YEAR

11/28/87

2b. HOUR

7 A M

3. SEX

female

4. RACE

white

5. DATE OF BIRTH

MONTH

DAY

YEAR

3

24

17

6. AGE (IN YEARS (LAST BIRTHDAY))

70

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Wisconsin

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George County

MD

10. CITY OR TOWN OF DEATH

Riverdale

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Leland Memorial Hospital

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
homemaker

12b. KIND OF BUSINESS OR INDUSTRY

n/a

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

Prince George

13c. CITY OR TOWN

College Park

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4621 Clemson Rd 20740

14. FATHER'S NAME

FIRST William

MIDDLE

LAST Hamsing

15. MOTHER'S MAIDEN NAME

FIRST Elizabeth

MIDDLE

LAST Tesch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

390-01-8808

17. INFORMANT

ADDRESS

John R. Langenegger same as #13

18. CAUSE OF DEATH (Enter only one cause per line for 18(a), (b) and (c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Adult Respiratory Distress Syndrome

DUE TO, OR AS A CONSEQUENCE OF

(b) Diffuse Pneumonitis

DUE TO, OR AS A CONSEQUENCE OF

(c) Cause unknown

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Heart failure

19a. DATE OF OPERATION

0 —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

—

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK ☐ NOTWHILE ☐ AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/27, 1987, to present, 1987, that (we) last saw the deceased alive on 11/27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Norton Elson

DEGREE

MD

ATTENDING  
PHYSICIANMEDICAL  
DIRECTORSTAFF  
PHYSICIAN

22c. DATE SIGNED

11/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Norton Elson MD

22e. ADDRESS

6525 Belcrest Rd #208 Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

12/1/87

23c. NAME OF CEMETERY OR CREMATORY

Ivy Hill Cemetery

23d. LOCATION

CITY OR TOWN Laurel Prince George Md STATE

24. FUNERAL DIRECTOR

Donald V. Borgwardt 4400 Powder Mill Rd  
Beltsville Md 20705

25a. DATE REC'D. BY REGISTRAR

DEC 01 1987

25b. REGISTRAR'S SIGNATURE

Julia Deason-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucy E. Latham			2a. DATE OF DEATH MONTH DAY YEAR NOV 13 1987			2b. HOUR 5:00 AM		
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 10 16 1895	6. AGE (IN YEARS LAST BIRTHDAY) 92			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. STATE MD			13b. COUNTY Washington, D.C.			13c. CITY OR TOWN Washington, D.C.		
14. FATHER'S NAME FIRST MIDDLE LAST Robert P. Vermillera			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Eubank			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b. SOCIAL SECURITY NO. 579-22-8390			17. INFORMANT ADDRESS Wallace L. Newman 3 Tempe Wick Rd. Mendham, N.J.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio vasopathy with Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Age</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-10-73</u> , 19 <u>73</u> to <u>11/12</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11-12-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Mark H. Pillor</u>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-13-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark H. Pillor, M.D.			22e. ADDRESS 6188 Oxon Hill Rd. Oxon Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/16/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.	
24. FUNERAL DIRECTOR NAME George P. Kalas			25a. DATE REC'D. BY REGISTRAR NOV 16 1987			25b. REGISTRAR'S SIGNATURE <u>David R. Rando</u>		

07503111111

074014 DEC-3 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LENA C. LEEDY		2a. DATE OF DEATH MONTH DAY YEAR 11 28 87		2b. HOUR 3 35PM M	
3. SEX Female.		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR May 14, 1881	
6. AGE (IN YEARS LAST BIRTHDAY) 106 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Old Rosedale Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Garfinckel Retired.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		13a. STREET ADDRESS / ZIP CODE 1801 Metzrtr Rd 20783	
13b. STATE Md.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME James Russell Leedy.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO. 357-07-5183		17. INFORMANT Robert R. Leedy		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia - recurrent DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Organic Brain Syndrome					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 11/26 to 11/28, 1987, that (we) lost saw the deceased alive on 11/28, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not view the body after death.					
22b. SIGNATURE Don H. Yablonsky		DEGREE no		22c. DATE SIGNED 11/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonsky, MD		22e. ADDRESS 10300 Greenbelt Rd #101 Seabrook, Md 20706			
23a. BURIAL, CREMATION, REMOVAL (EXCEPT) Burial.		23b. DATE Dec 5 1987		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Norton Virginia		23e. DATE REC'D. BY REGISTRAR DEC 03 1987			
23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

982

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

100-100-100

X

X

100-100-100

100-100-100



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

1a. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

*Bernard*

*Lemaire*

2a. DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
*11-30 1987*

2b. HOUR  
M  
*11:30*

3. SEX  
*Male*

4. RACE  
*White*

5. DATE OF BIRTH  
MONTH DAY YEAR  
*1-22-19*

6. AGE (IN YEARS)  
LAST BIRTHDAY  
MONTHS DAYS HOURS MIN  
*68*

IF UNDER 1 YR.  
MONTHS DAYS

IF UNDER 24 HRS.  
HOURS MIN

2c. DATE PRONOUNCED DEAD  
MONTH DAY YEAR  
*11-30 1987*

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
*Mass.*

7b. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

8. MARRIED  
☒ NEVER MARRIED  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
*Prince George's*

10. CITY OR TOWN OF DEATH  
*Clinton*

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
*Southern Maryland Hospital*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
*Warrant Officer*

12b. KIND OF BUSINESS OR INDUSTRY  
*USAF Ret.*

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
*Maryland*

13b. COUNTY  
*P. G.*

13c. CITY OR TOWN  
*Clinton*

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS  
*6720 Crafton Land 20735*

14. FATHER'S NAME  
FIRST MIDDLE LAST  
*Roland Lemaire*

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
*Beatrice Rivet*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(IF YES, GIVE WAR OR DATES)  
Yes ☒ No ☐  
*1949-1968*

16b. SOCIAL SECURITY NO.  
*031-05-1678*

17. INFORMANT ADDRESS  
*Mary Lemaire Same as 13 A-E*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

*Sunshot wound to the head*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY  
YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
*Home*

21d. HOW INJURY OCCURRED, (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

*self-inflicted*  
*6720 Crafton Land, Clinton, Pr. George, Md*

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE  
*Augusto P. Rodriguez*  
EXAMINER'S NAME (TYPE OR PRINT)  
*Augusto P. Rodriguez, M.D.*

TITLE (SPECIFY)  
*Deputy*

MEDICAL EXAMINER

DATE SIGNED  
*11-30-87*

ADDRESS  
*5009 Rayburn Ct, Temple Hills, MD*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
*Burial*

23b. DATE  
*12/09/87*

23c. NAME OF CEMETERY OR CREMATORY  
*Arlington National Cem.*

23d. LOCATION  
CITY OR TOWN COUNTY STATE  
*Arlington Arlington Va.*

24. FUNERAL DIRECTOR NAME  
*Lee Funeral Home, Inc.*

25a. DATE REC'D. BY REGISTRAR  
*DEC - 9 1987*

25b. REGISTRAR'S SIGNATURE  
*Julia Benson-Randall*

6633 Old Alexander Ferry Rd Clinton, Md 20735

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17

(VR A15 ME)

1001-00537

72265 NOV 18 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 / 3 3 3 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RANDY MICHAEL LEONARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 11, 1987</b>		2b. HOUR <b>12:40 P</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 9, 1952</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3804 Nicholson Street</b>		12. (SUPERVISOR'S) AMERICAN SOC. Graphic Arts PERSONEL/ADM.		
13a. STATE <b>Wash. DC</b>	13b. COUNTY <b>Wash. DC</b>	13c. CITY OR TOWN <b>Wash. DC</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2501 Q street, N.W. 20007</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward J. Leonard</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jessie C. Vaughn</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-64-7379</b>		17. INFORMANT <b>3804 Nicholson Street, Hyattsville, Md. 20782</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiorespiratory Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Cytomegaloviral Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Acquired Immune Deficiency Syndrome**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>86</b> to <b>11-11-</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11-10-</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>LM Bruni MD</b>	DEGREE <b>SUSAN JOYCE R.N.</b>	22c. DATE SIGNED <b>11-12-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Larry M. Bruni</b>	22e. ADDRESS <b>2112 F St., N.W., Suite 603, Wash. DC</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>11-14-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>
24. FUNERAL DIRECTOR <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>	
4739 Baltimore Ave., Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE <i>Julia Tonder-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file the death certificate, pages 1 and 2, with the State Dept. of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked or item 18 shows any injury, or if the death was the result of a traumatic event, the medical examiner should be notified at once.

BP

DHMH 16-60M 7/84  
(VRA 15, 4)

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NOV 20 1987

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) JAMES C. LESTER			2a. DATE OF DEATH MONTH DAY YEAR 11-10-87		2b. HOUR 9:45 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel/Beltsville Home Nursing		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) A.C. Installer	12b. KIND OF BUSINESS OR INDUSTRY Automotive	
13a. STATE Maryland		13b. COUNTY Pr. George's	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Reece		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Mae Henshaw			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 412-18-4798		17. INFORMANT Brenda Sue Thomas	
				ADDRESS 8509 Church Lane Bowie, Maryland 20715	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Cerebrovascular occlusive disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/19</u> , 19 <u>86</u> , to <u>11/10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Gregory A. Compton MD</u>		DEGREE MD		22c. DATE SIGNED 11-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A. COMPTON MD		22e. ADDRESS 8317 Cherry Lane Laurel MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE NOV 14, 1987		23c. NAME OF CEMETERY OR CREMATORY National Memorial Pk. Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR NOV 19 1987	
				25b. REGISTRAR'S SIGNATURE Julia Twiss-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOV 18 1953

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Grace N. Lingrell			2a. DATE OF DEATH MONTH DAY YEAR 11-27-87		2b. HOUR 9:37 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-06-07	6. AGE (IN YEARS LAST BIRTHDAY) 80	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD		
10. CITY OR TOWN OF DEATH LAWRENCE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Lawrence BELTSVILLE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) printer's helper	12b. KIND OF BUSINESS OR INDUSTRY US Govt	
13a. STATE MD	13b. COUNTY Prince George	13c. CITY OR TOWN BELTSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12000 Gunpowder Rd 20705	
14. FATHER'S NAME FIRST MIDDLE LAST Ocea Erie Newell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle May Norman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-60-5141		17. INFORMANT ADDRESS Alton L. Lingrell 12000 Gunpowder Rd. 20705	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MALIGNANT MELANOMA</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>LARGE PANCREATIC MASS.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11/26/87</u> to <u>11/27/87</u> , that (I) (we) lost saw the deceased alive on <u>11/26/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.					
22b. SIGNATURE <u>Abdul Nayeem M.D.</u>				22c. DATE SIGNED 11/27/87.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Nayeem, M.D.				22e. ADDRESS 345 Ft Meade Rd Ste 100 Laurel Md 20707	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/30/87		23c. NAME OF CEMETERY OR CREMATORY Bethesda U. M. Church Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Damascus Montg. Md.		23e. DATE REC'D. BY REGISTRAR DEC 01 1987			
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt		4400 Powder Mill Rd. Beltsville Md 20705		25. REGISTRAR'S SIGNATURE John Gordon-Randall	

MEDICAL CERTIFICATION

982

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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073702 DEC-28

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ARCHIE LOCKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/26/87</b>		2b. HOUR <b>8:30</b> M
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 14 1963</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>24</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MD. Hosp. CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Porter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RCA</b>
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1524 F Street, N.E. # 125</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jessie Locke</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia Cox</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-12-8520</b>		17. INFORMANT <b>Mary Locke</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>MONTHS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>11/26</b> , 19 <b>87</b> , to <b>11/26</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>11/26</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>P. Wisotsky</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/26/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. Wisotsky M.D.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-01-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover PG Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Larry Carter</b>		ADDRESS <b>14616 Goodhope Rd SE</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000

DEC 1 1960

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33379

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR			
Grady Allen Lumpkin						11/ 21/ 87						M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			
Male		Black		11 30 35		52 YRS.						11/ 23/ 87 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
South Carolina				U.S.A.								Prince George's County, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Beltsville				12051 Indian Creek St.				Painter				Pvt.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11370 Evans Trail 20705			
MD				PG		Beltsville									
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Louis Lumpkin						Lee Tillman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO						N/A		578443564 Kathleen Wilson/11370 Evans Trail							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Gunshot Wound of Head															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11/21/ 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) self inflicted wound							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in auto at				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12051 Indian Creek St., Beltsville, Pr. Geo. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Dennis F. Smyth, M.D.				Assistant				11/23/87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				12/5/87		Harmony				Landover PG Md					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J.B. Jenkins/7474				LANDOVER RD				DEC 07 1987		Julia Gordon-Randall					

DHMH - 17  
(VR A15 ME (5))

07/84  
25M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17  
(VR A15 ME (5))

BP

NOV 23 1950



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DOROTHY LUTHOLTZ</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11. 23. 87</b>		2b. HOUR <b>4:12 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/26/24</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Film Processor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Laurel</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8735 Contee Rd 20708</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Scott</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Bates</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Robert Lutholtz 8735 Contee Rd Laurel MD 20708</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASHD</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ISCHEMIC CARDIOMYOPATHY</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>7</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>2</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11.21.1987</b> , to <b>11.23.1987</b> , that (I) (we) last saw the deceased alive on <b>11.23.1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>ASIF S. QADRI</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ASIF S. QADRI</b>		22e. ADDRESS <b>4700 BERWYN HOUSE RD, College PK MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/25/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Lukes Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Redland Montgomery MD</b>		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <b>Peck Funeral Home Inc</b> 7601 Sandy Spring Rd Laurel MD 20708					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and satisfactorily filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James Joseph MacDonald			2a. DATE OF DEATH MONTH DAY YEAR November 10, 1987		2b. HOUR 3:15 P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 19, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Adelphi	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman	12b. KIND OF BUSINESS OR INDUSTRY Washington Gas Light Co.	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11395 Old Columbia Pike #B-12 20904	
14. FATHER'S NAME FIRST MIDDLE LAST James Thomas MacDonald			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine A. Nyland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-32-4228	17. INFORMANT Daughter ADDRESS 12930 Kentbury Drive Clarksville, Maryland 21029		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiovascular thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> <u>2 weeks</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>MAY 128</u> 19 <u>86</u> to <u>NOV 10</u> 19 <u>87</u> , that (we) lost saw the deceased alive on <u>10 NOV 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Walter E. Goetz</u> MD				22c. DATE SIGNED 10 NOV 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD 20902	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Nov. 13, 1987	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md. 20901			25a. DATE REC'D BY REGISTRAR NOV 16 1987		

5051 100 7 20 05



073305 NOV 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ETTA	MIDDLE V.	LAST MARSHALL	2a. DATE OF DEATH MONTH DAY YEAR 11 22 87		2b. HOUR 6 36PM M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 22 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Private
13a. STATE Maryland		13b. COUNTY P. Georges		13c. CITY OR TOWN C. Heights		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4315 R Street 20743
14. FATHER'S NAME FIRST MIDDLE LAST Dennis Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Hebron		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b. SOCIAL SECURITY NO. 578-34-5758		17. INFORMANT Joseph W. Marshall			ADDRESS 4315 R. Street Cap. Heights, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable acute myocardial infarction</u> 912 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Possible aspiration with acute respiratory decompensation</u>								
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Ronald Henry M.D.</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD HENRY, M.D.				22e. ADDRESS 9470 ANNAPOLIS RD., LANHAM, MD. 20785				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-27-87		23c. NAME OF CEMETERY OR CREMATORY Maryland National		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Maryland		
24. FUNERAL DIRECTOR NAME <u>J. J. Perkins</u>				ADDRESS <u>7470 Landover Ave.</u>		25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Dinkins-Rudner</u>

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
IDA		LORRAINE		MARSHALL				11-18-87				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Black	May 17, 1927		60						11-18-87		10:40P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA		WIDOWED		DIVORCED		XXX Prince George's County				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George's County Hospital		Housekeeper									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		PG		Landover		YES <input type="checkbox"/> NO <input type="checkbox"/>		1107 Capitol View Drive					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Joseph Griffin		Ida Powell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		218 30 3980		Cecelia Griffin-sister-1638 40th									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED					
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				9:18p 11-18-87				subject shot					
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				home				1107 Capitol View Drive Landover, Maryland					
22a. I certify that I took charge of the remains described above, held on													
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Korell, M.D.				Assistant				11-19-87					
EXAMINER'S NAME				ADDRESS									
(TYPE OR PRINT)				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				Nov. 24 1987				Harmony Memorial Park					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Stewart				NOV 24 1987				Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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71805 NOV 16 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOIS WOOD MARSHALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 07 1987</b>			2b. HOUR <b>3:10am</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 17, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Camp Springs</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Malcom Grow Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2701 Lyn Place/20715</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Justin C. Wood</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Decker</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>218-16-7991</b>		17. INFORMANT <b>Judy Coleman, 3811 Abdingdon St., Arlington, VA 22207</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTIPLE MEDICAL PROBLEMS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC ALCOHOLISM AND MALNUTRITION</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>17 OCT 19 87</b> , to <b>07 NOV 19 87</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>07 NOV 19 87</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE <b>Edward W. Kolar MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>07 NOV 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. KOLAR, CAPT, USAFMC</b>					22e. ADDRESS <b>MGUSAFMC, ANDREWS AFB, MD., 20331-5300</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 7, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>				
25b. REGISTRAR'S SIGNATURE <b>John S. ...</b>									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

71803 NOV 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES Willard MARTIN			2a. DATE OF DEATH MONTH DAY YEAR 11 28 87		2b. HOUR 9 45PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 14, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Title Dept.	12b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P. G. 13c. CITY OR TOWN Riverdale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5011 Riverdale Rd. #7 20737	
14. FATHER'S NAME FIRST MIDDLE LAST James Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Warnick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) 1944-1946	17. INFORMANT 578-38-8661	ADDRESS Bettie M. Martin Same as 13 A-E		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>dehility + pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebrovascular thrombosis = triplegia</i> (c) <i>Cerebrovascular atherosclerosis</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic bronchitis</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-28-87 to 11-28-87, that (I) (we) lost saw the deceased alive on 11-28-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>James Harding</i>			22c. DATE SIGNED 11/29/87	22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Harding	
22e. ADDRESS 6005 Landover Rd. Cheverly Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11/30/87	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's Md.		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			25. DATE REC'D BY REGISTRAR DEC 02 1987		
26. ADDRESS 16633 Old Alexander Ferry Rd. Clinton, Md 20735			27. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 7 3 3 3 8 6

1. DECEASED NAME (TYPE OR PRINT) Charles William Martz			2a. DATE OF DEATH MONTH DAY YEAR November 15, 1987		2b. HOUR 8: PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 17, 1931		6. AGE (IN YEARS (LAST BIRTHDAY)) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician	12b. KIND OF BUSINESS OR INDUSTRY Electronic	
13a. STATE Maryland	13b. COUNTY Pr. Georges	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8102 Sonar Road 20735	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Martz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucina Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes Korea		16b. SOCIAL SECURITY NO. 198-28-2998		17. INFORMANT Nancy Martz	
				ADDRESS Same as # 13 a-e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Wegener's Granulomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos 4 mos
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>87</u> , to <u>11/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles F. Colao</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov. 16, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Colao, MD		22e. ADDRESS 3710 Riviera St. Marlow Heights, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov 18, 1987	23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home		ADDRESS Clinton, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 18 1987	
		25b. REGISTRAR'S SIGNATURE <u>Julia Swisher-Randall</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM RAYMOND MASON</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 16 1987</b>		2b. HOUR <b>11:00A<sup>M</sup></b>	
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 3, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		IF UNDER 24 HRS. HOURS MIN. <b>MD.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>							
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AMI DOCTORS' HOSPITAL OF PR. GEO</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Ind.</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Mt. Rainier</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4204 31st Street, 20712</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Mason</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNAVAILABLE</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW-1 578-03-8081</b>		17. INFORMANT ADDRESS <b>Gladys H. Mason, Same as line #13</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>day</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cardiac Arrhythmia</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>11-15-87</b> to <b>11-16-87</b> , that (I) (we) last saw the deceased alive on <b>11-16-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-16-87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHANNES SAHAKIAN, M.D.</b>				22e. ADDRESS <b>5632 Annapolis Rd., Bladensburg, Md. 20710</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-18-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G., Md.</b>							
24. FUNERAL HOME OR OTHER PLACE WHERE FUNERAL SERVICES WERE HELD NAME ADDRESS <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland</b>													
DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>						REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH ELIZABETH MATHER			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 13 1987		2b. HOUR 12:35P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1921		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 103 Carroll Road 21061		12b. KIND OF BUSINESS OR INDUSTRY Hospital		
14. FATHER'S NAME FIRST MIDDLE LAST Frank F. Fort		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Bullock		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		
16b. SOCIAL SECURITY NO. 217.30.3662		17. INFORMANT (Brother) Ben B. Fort		ADDRESS 5101 Old Randleman Rd. Greensboro, N.C. 27406		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive GI Bleed</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESOPHAGEAL VARICES</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>POLYCYTHEMIA VERA</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>11-11</u> , 19 <u>87</u> , to <u>11-13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Jan S. Martin</u>		DEGREE MD		22c. DATE SIGNED 11-13-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANET MARTIN, M.D.		22e. ADDRESS 6510 Kenilworth Ave., #2400, Riverdale Md. 20737				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 16, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A A Co. Md.		24. FUNERAL DIRECTOR NAME <u>R. A. Singleton</u> ADDRESS Singleton Funeral Home Glen Burnie, Maryland				
25a. DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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073967

FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pearl L Matthews			2a. DATE OF DEATH MONTH DAY YEAR 11-24-87			2b. HOUR 3:40 AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 12, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp.				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Pr. Geo		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 500 9th St - 20707	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Mitchell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Queen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-30-3839		17. INFORMANT Bessie Matthews (daughter) SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic Cardiovascular Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 1925 to 11-24-1987, that (I) (we) last saw the deceased alive on 11-23-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Arthur A. Warren MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-24-87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) W.A. Warren						22e. ADDRESS 321 Prince Georges St Laurel 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-30-87		23c. NAME OF CEMETERY OR CREMATORY Queen's Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Beltsville, Pr. Geo, MD		
24. FUNERAL DIRECTOR NAME George R. Snowden						ADDRESS Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR NOV 27 1987	
25b. REGISTRAR'S SIGNATURE Julia Dendron-Randall									

BP

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. In the second part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

3. In the third part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

4. In the fourth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

5. In the fifth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.



073857 DEC-30

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 33390

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM E MAZYCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 29 1987</b>			2b. HOUR <b>12:40p<sub>M</sub></b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 15, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AMI Doctor's Hospital of Pr. Geo.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Co. Storekeeper</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Glen Dale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John C. Mazyck</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beatrice Dent</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>710-03-8196</b>		17. INFORMANT ADDRESS <b>Roger W. Mazyck, Same as # 13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular failure</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>renal failure</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>severe arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>							
19a. DATE OF OPERATION <b>10/22/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>gangrene of left foot</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/22</b> 19 <b>87</b> to <b>11/29</b> 19 <b>87</b> that (I) (we) lost saw the deceased alive on <b>11/29</b> 19 <b>87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <b>Bruce S. Lowman</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/30/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bruce Lowman, M.D.</b>				22e. ADDRESS <b>5901 Medical Terrace, Cheverly, Md. 20785</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 3, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, P.G., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>				16000 Annapolis Road Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

708-301 720850

DEC 03 1987

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>FLORENCE M. McCABE</b>		2a. DATE OF DEATH MONTH <b>NOVEMBER</b> DAY <b>23</b> YEAR <b>87</b>		2b. HOUR <b>115A</b> M	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>DEC.</b> DAY <b>2</b> YEAR <b>1895</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE</b> MD.		
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL MANOR</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERICAL</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
13a. STATE <b>MD.</b>	13b. COUNTY <b>PRINCE GEORGE</b>	13c. CITY OR TOWN <b>HYATTSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>4922 LA SALLE RD. 20782</b>	
14. FATHER'S NAME FIRST <b>CHRISTOPHER J.</b> MIDDLE <b></b> LAST <b>McCABE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>CUNNINGHAM</b> LAST <b>HAM</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>113-09-6916</b>		17. INFORMANT <b>ATTORNEY</b> ADDRESS <b>J.E. McNEIL - 1701 N ST. N.W. WASH D.C.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROGRESSIVE CEREBRAL THROMBOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC CARDIORENAL VASCULAR DISEASE</b>		<b>YEARS</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ATRIAL FIBRILLATION, CONGESTIVE HEART FAILURE</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 1983</b> to <b>NOVEMBER 23, 1987</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 22, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <b>Marta Anne Schneider M.D.</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>	22c. DATE SIGNED <b>11/23/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTA ANNE SCHNEIDER M.D.</b>		22e. ADDRESS <b>5401 MACARTHUR BLVD NW WASH D.C. 20016</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>DEC. 1, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY NAME CEM.</b>	23d. LOCATION CITY OR TOWN <b>Jersey City</b> COUNTY <b>N.J.</b> STATE <b></b>
24. FUNERAL DIRECTOR <b>James J. DeVol</b>		25. DATE REC'D BY REGISTRAR <b>DEC 7 1987</b>	26. REGISTRAR'S SIGNATURE <b>James J. DeVol</b>

STATE OF NEW YORK  
IN SENATE  
JANUARY 12, 1901

180-30 65 17

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 12, 1901

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1901

07-1-1-2-8 NOV 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, register, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner will be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HAZEL MAY MC CARTEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV, 2<sup>nd</sup> 1987</b>		2b. HOUR <b>2<sup>00</sup> PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 19, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD</b>	
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5406 13th Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House wife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince Geo.</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Shaw</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida M. King</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-36-1951</b>		17. INFORMANT <b>8767 Contee Road,</b> <b>Mr. Gene Shaw, Laurel, Md. 20708</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Diabetes Mellitus</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>1983</b> , to <b>NOV</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Oct 28</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mark K. Li</i>		DEGREE <b>MD</b>		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark K. Li</b>		22e. ADDRESS <b>Suite #205</b> <b>1140 Varnum St., N.E., Wash. D.C. 20017</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-05-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G., Maryland</b>	
24. FUNERAL HOME NAME ADDRESS <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.O. BOX 1140, Baltimore Ave., Hyattsville, Maryland</b>					
DATE REC'D. BY REGISTRAR <b>NOV 06 1987</b>				REGISTRAR'S SIGNATURE <i>Widson Randall</i>	

78 G. VOL 2-54-1-70

074980 DEC 15 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33393

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY MCCARTHY			2a. DATE OF DEATH MONTH DAY YEAR 11-29-87		2b. HOUR 9:07AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR MAY 13 1914	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR	12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. STATE M.D.			13b. COUNTY P.G.	13c. CITY OR TOWN GLENARDEN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME SCOTT MIDDLE MCCARTHY			15. MOTHER'S MAIDEN NAME ANNA FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-09-0054	17. INFORMANT ROXIE MCCARTHY 3209 JOHNSON CT. GLENARDEN M.D.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Subdural Hematoma</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Abnormal Liver Function Tests.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/28/87</u> to <u>11/29/87</u> , that (I) (we) last saw the deceased alive on <u>11/28/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Revathy Murthy</u>		DEGREE M.B.B.S.		22c. DATE SIGNED 11/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REVATHY MURTHY M.D.		22e. ADDRESS 6130 LANDOVER RD. LANDOVER, M.D.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-5-87	23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER P.G. MARYLAND		
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C.		25a. DATE REC'D. BY REGISTRAR DEC 07 1987			
		25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Budner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coffin papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must file the medical certificate.





71882 NOV 16 87

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDGAR JAMES McCLOY			2a. DATE OF DEATH MONTH DAY YEAR 11-11-87		2b. HOUR 3:37 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 9 22 71		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quartermaster		12b. KIND OF BUSINESS OR INDUSTRY Metro. Police
13a. STATE Maryland		13b. COUNTY Pr. Georges	13c. CITY OR TOWN Camp Springs	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Jefferson McCloy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Louise Rollins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-54-9967		17. INFORMANT ADDRESS Kimberly A. McCloy as in item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DIS. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic HEART DIS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a SMOKERS LUNGS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1974 to 11-11-87, that (we) last saw the deceased alive on 6-11-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE R.A. McConnaughy MD		DEGREE		22c. DATE SIGNED 11-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.A. McCONNAUGHY MD		22e. ADDRESS 5618 ST. BARNABUS Rd Oxon Hill Md 20745			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-16-87		23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.					
24. FUNERAL DIRECTOR NAME G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md		25a. DATE REC'D. BY REGISTRAR NOV 13 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

BP

Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1863 NOV 12 63

RECEIVED BY THE  
LIBRARY OF THE  
CONGRESS

Mr. C. C. C.

INTEREST

INTERESTING CAROLINA

INTERESTING CAROLINA

INTERESTING CAROLINA

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070900 NOV-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	23b. DATE <b>11-2-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Balto., Md.</b>	23d. LOCATION CITY OR TOWN <b>Balto., Md.</b>	23e. DATE REC'D BY REGISTRAR <b>NOV 05 1987</b>	23f. REGISTRAR'S SIGNATURE <i>Julia D. [Signature]</i>
24. FUNERAL DIRECTOR NAME ADDRESS <b>State Anatomy Board Balto., Md.</b>					

1- STATE REGISTRAR						FOR STATE REGISTRAR						STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						33395					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Hall Richard McComas</b>												2a. DATE KNOWN OF DEATH ESTIMATED <b>NOV 2 1987</b>				2b. HOUR <b>P</b>							
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 7 34 53</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>53 YRS.</b>		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <b>NOV 2 1987</b>				2d. HOUR <b>11 22</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Calver</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges MD.</b>											
10. CITY OR TOWN OF DEATH <b>Calver</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8824 Hunting Line Apt 203</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGINEER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>WESTINGHOUSE</b>											
13a. STATE <b>Md.</b>				13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Calver</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8824 Hunting Line Apt 203</b>				20810									
14. FATHER'S NAME FIRST MIDDLE LAST <b>DONALD MCCOMAS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>212-30-0480</b>				17. INFORMANT ADDRESS <b>ALBERT BOWEN - EXECUTOR 752-4660</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>																							
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>John H. Rogers</i>				TITLE (SPECIFY) <b>M.D. Dir.</b>				MEDICAL EXAMINER				DATE SIGNED <b>NOV 2 1987</b>											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			

07/84 BP  
25M  
DHMH - 17  
(VR A15 ME (5))

070000 101-201



101-201

*[Faint, illegible handwritten text]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 3 9 6

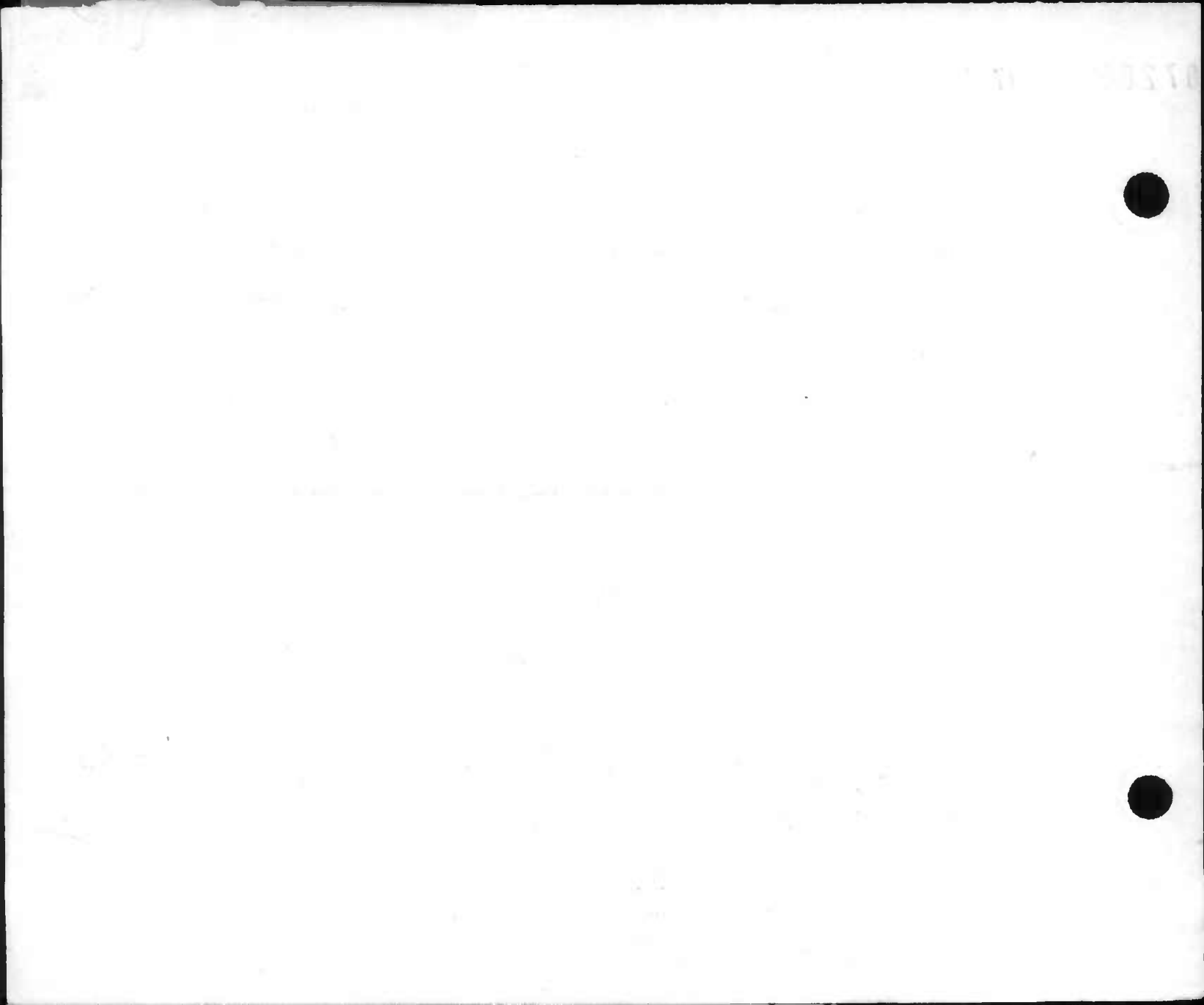
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Florence McCoy</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 12 1987</b>		2b. HOUR P <b>10:20 M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 22 1900</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George MD.</b>		
10. CITY OR TOWN OF DEATH <b>Riverdale</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr George</b>	13c. CITY OR TOWN <b>Dist Hgts</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1910 Harwood Road 20747</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Wallace</b>		15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>Alice Benson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577 12 4766</b>	17. INFORMANT ADDRESS <b>Gloria Sumner Same as #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Organic brain syndrome</u>					
19a. DATE OF OPERATION <u>10/30/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>1982</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from <u>10/30/87</u> to <u>11/12/87</u> , that (b) we lost sight of the deceased on <u>11/12/87</u> , and that (c) our opinion death occurred on the date and hour and from the causes stated above (do not check this box) (see the body after death)					
22b. HIGH NURSING <u>Peter M. Schissler, M.D.</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/13/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Peter M. Schissler, M.D.</b>		22e. ADDRESS <b>7500 Greenway Center Drive Greenbelt, Maryland 20770</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>16 Nov 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Church Cem Forestville Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert E Wilhelm Funeral Home Suitland Maryland</b>		25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>NOV 16 1987</b> <u>John Davidson-Randall</u>			

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



073121 NOV 25 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33397

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy L. McDowell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-16-87</b>			2b. HOUR <b>10:01 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 25, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>		7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD			
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1140 12th Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U S Govt</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>P G</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard McDowell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Roxie Perkins</b>			16. STREET ADDRESS <b>1140 12th Street 20707</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>579 10 3986</b>		17. INFORMANT ADDRESS <b>H. Stanley McWhorter 6100 Westchester Pk College Park, Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b). <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c). <b>Chronic Obstructive Lung Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>November 19, 87</b> to <b>11-16-</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-2-</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <b>William A. Warren, MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-16-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W-A. Warren</b>						22e. ADDRESS <b>321 Prince George St. Laurel 20707</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Nov. 17, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Md</b>		
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, Laurel, Md</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Alia Tindon-Rudner</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The registrars that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

Proctor & Co. Ltd.

10, Abchurch Lane, London, E.C. 4

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 14th inst.

in relation to the above mentioned matter.

I am sorry to hear that you are unable to supply the information requested.

I am, Sir, very respectfully,

Yours faithfully,  
W. H. Proctor

W. H. Proctor & Co. Ltd.



074-324 DEC -87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

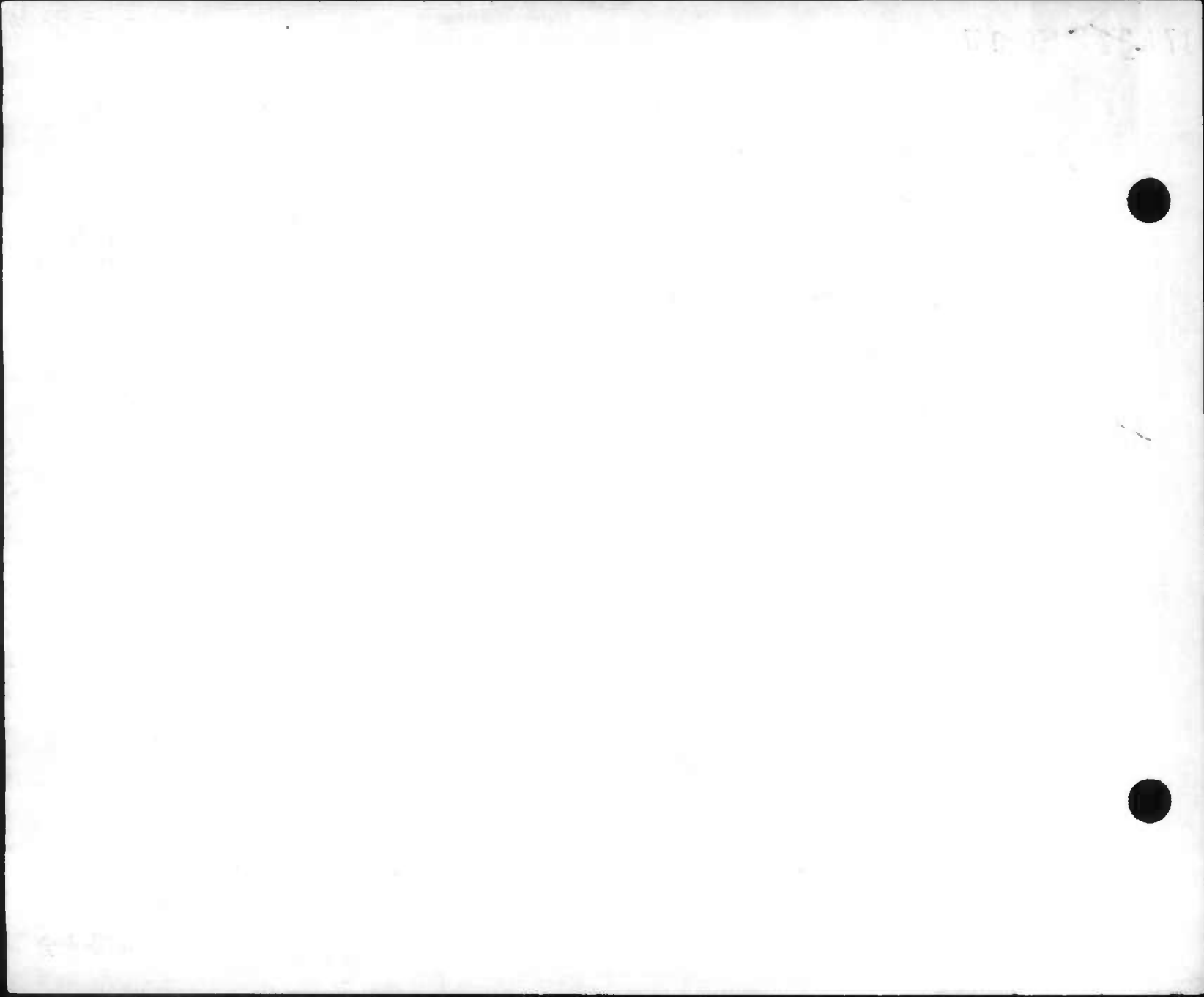
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas James McElrath			2a. DATE OF DEATH MONTH DAY YEAR Nov. 30 1987		2b. HOUR 3.38AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 20 1924		
6. AGE (IN YEARS LAST BIRTHDAY) 63		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		10. CITY OR TOWN OF DEATH Lanham		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10214 Buena Vista Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Forensic Tech		12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Lanham		
14. FATHER'S NAME FIRST MIDDLE LAST Milas McElrath		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Smith		16. STREET ADDRESS 10214 Buena Vista Ave		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 579-34-7070		17. INFORMANT ADDRESS Mary McElrath/10214 Buena Vista Ave Lanham, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Yr.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Oct. 15 1987, to Nov. 30 1987, that (I) (we) last saw the deceased alive on Nov. 29 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE B Kessel		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec 2 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Kresseo		22e. ADDRESS 2141 K St. N.W. Wash. D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National		
23d. LOCATION Arlington		23e. LOCATION Arlington		23f. LOCATION VA		
24. FUNERAL DIRECTOR NAME J.B. Jenkins FH/7474 Landover Rd/Landover, Md		25a. DATE REC'D. BY REGISTRAR DEC 07 1987		25b. REGISTRAR'S SIGNATURE Julia Denson-Rudner		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 33399

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD D. MCGUIRE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-08-87</b>		2b. HOUR <b>310 PM</b>	
3. SEX <b>MALE</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 3 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Forestville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2514 Newglen Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Forestville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2514 Newglen Ave. 20747</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George D. McGuire</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary M. Dudding</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>1935-K938</b>		17. INFORMANT ADDRESS <b>Michael E. McGuire 112 Colfax Dr. Manassas Park, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>ALCOHOL ABUSE.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-08-87</b> 19 <b>87</b> , to <b>11-08-87</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-08-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael F. York MD</b>		DEGREE		22c. DATE SIGNED <b>11-08-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL F. YORK MD</b>		22e. ADDRESS <b>5506 GREEN LANDING RD UPPER MARLBORO, MD, 20772</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/10/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans Cemetery Cheltenham P.G. Maryland</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		ADDRESS <b>6160 Oxon Hill Rd Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>	
		25b. REGISTRAR'S SIGNATURE <b>Asia Gordon-Randall</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE MCMILLAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-10-87</b>		2b. HOUR <b>4.45P</b> M	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 18 1905</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.		
13a. STATE <b>D.C.</b>		13b. COUNTY <b>N.W.</b>		13c. CITY OR TOWN <b>Washington</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5728 3rd St. NW</b>		<b>99999</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Duffie McMillan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lou A. Gilchrist</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>578 18 1910</b>		
17. INFORMANT <b>Janie Stewart</b>		11504 Chantilly Lane <b>Mithellville, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/10/87</b> to <b>11/10/87</b> , that (I) (we) last saw the deceased alive on <b>11/10/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>Revathy Murthy</b> MD		
22c. DATE SIGNED <b>11/13/87</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <b>6130 LANDOVER RD, LANDOVER, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1987 November 14</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>		24. FUNERAL DIRECTOR NAME <b>McGuire Funeral Service, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1987</b>		
25b. REGISTRAR'S SIGNATURE <b>John R. Riddell</b>		25c. ADDRESS <b>7400 Ga. Ave., N.W. DC</b>		25d. DATE REC'D. BY REGISTRAR <b>NOV 20 1987</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

B 7 33401

1. DECEASED NAME (TYPE OR PRINT) <b>MAZIE B MEMOORE</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>12</b> YEAR <b>87</b>		2b. HOUR <b>11:45 AM</b>
3. SEX <b>F</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>6</b> YEAR <b>07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MONROE, NC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES MD</b>	
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Ret</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>		13b. COUNTY <b>PRINCE GEORGES</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>BECK</b> LAST <b>HAM</b>			15. MOTHER'S MAIDEN NAME FIRST <b>ONE</b> MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>577-58-9300</b>		17. INFORMANT <b>HELEN CAMERON</b>	
				ADDRESS <b>196 W. BERRY BLVD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Possible Signs - UTI - Hypertension - CHF</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/1/87</b> to <b>11/12/87</b> , that (I) (we) lost saw the deceased alive on <b>11/12/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE		22c. DATE SIGNED <b>11/13/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ESTHER MASTATHAN</b>		22e. ADDRESS <b>2235 26th Ave NE 20748</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Church Cem</b>		23b. DATE <b>11/21/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cem</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCK HILL SC</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1987</b>			
24. FUNERAL DIRECTOR NAME <b>RHINE FH</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then, please attach this certificate to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

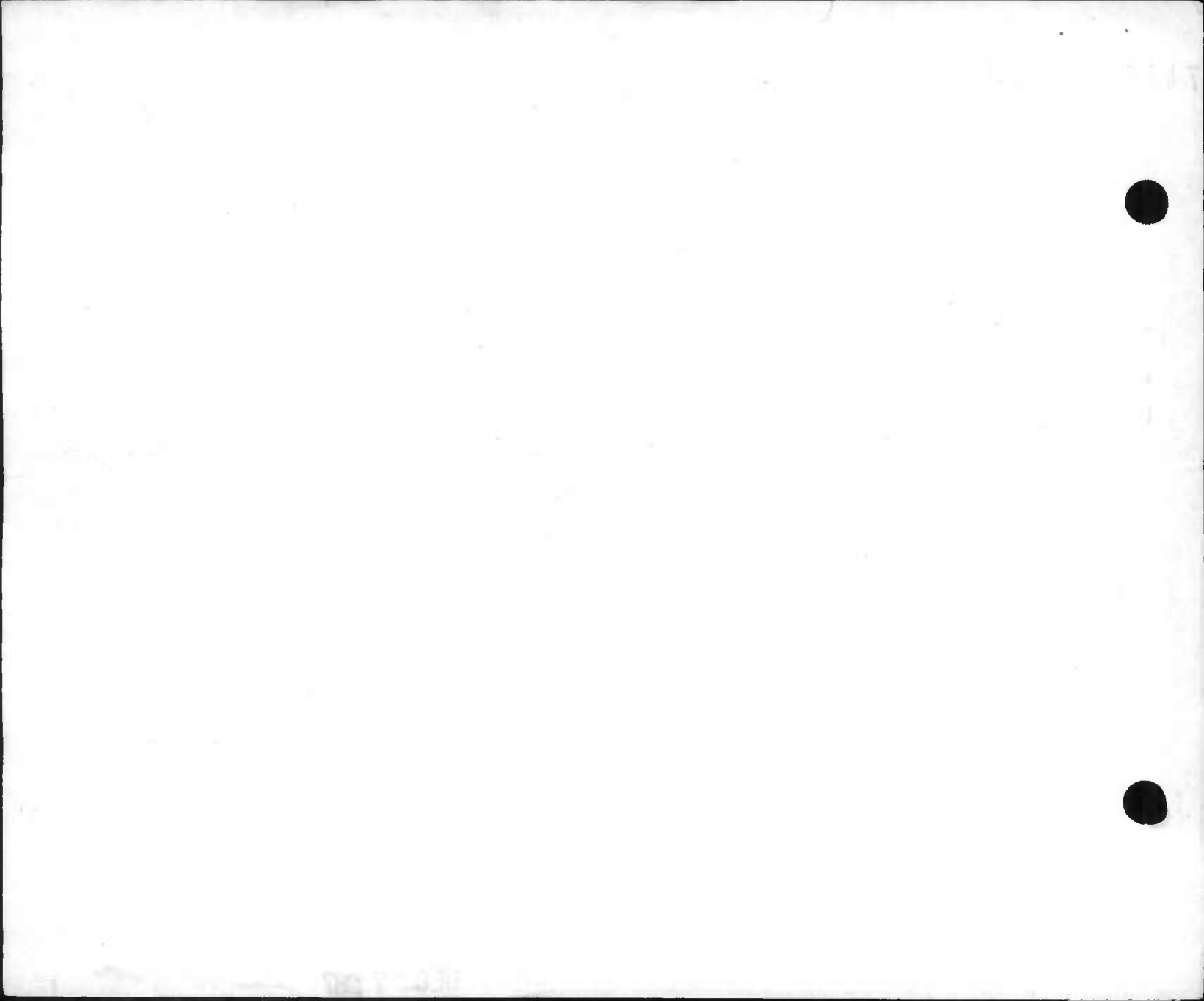
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 3 3 4 0 2			
1- STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jim B. McQuitty					2a. DATE OF DEATH MONTH DAY YEAR 11 30 87				2b. HOUR 6:30A M				
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JAN 13 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.							
10. CITY OR TOWN OF DEATH ADELPHI		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1908 SARATOGA DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIST		12b. KIND OF BUSINESS OR INDUSTRY NAVY DEPT.					
13a. STATE MARYLAND				13b. COUNTY PR GEORGES		13c. CITY OR TOWN ADELPHI		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1908 SARATOGA DRIVE 20783			
14. FATHER'S NAME FIRST MIDDLE LAST WALTER HERMAN MCQUITTY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIS HOGUE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1941-1945		17. INFORMANT ADDRESS 499-30-5272		LORRAINE N. MCQUITTY/WIFE/SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Sarcoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1.5 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left sarcoma to spread (c) cell carcinoma										1.5 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/30 19 86 to 11/30 19 87, that (I) (we) last saw the deceased alive on 11/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Donald E. Dillon						DEGREE Dr. D. L. Lister		22c. DATE SIGNED 3 Dec 87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon						22e. ADDRESS 2901 Olney-Sandy Spring Rd Olney MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE DEC 3, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						DEC-7-1987							

BP

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(VRA 15, 4) 7/78



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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDGAR POE MILLAR</b>		2a. DATE OF DEATH <b>November 9, 1987</b>		2b. HOUR <b>12:26 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>04<sup>TH</sup>/12/1919<sup>YEAR</sup></b>	
7a. BIRTHPLACE <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Southern Maryland Hospital Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co., MD.</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Charles La Plata</b>		12a. USUAL OCCUPATION <b>Retired</b>	
14. FATHER'S NAME <b>Charles Wallace Millar</b>		15. MOTHER'S MAIDEN NAME <b>Edna Louise Simmons</b>		12b. STREET ADDRESS / ZIP CODE <b>Star Rt. 1, Box 1206, Piska</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-12-1637</b>		17. INFORMANT <b>Russell Millar, Son, Hollywood, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>generalized atherosclerosis</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>chronic obstructive pulmonary disease</b>					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>N/A</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-22</b> , 19 <b>87</b> , to <b>11-9</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-9</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Fadel</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>11-9-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Abdul H Fadel</b>		22e. ADDRESS <b>18-N 301 Hwy X Capital MD 20646</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/13/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Durham Cemetery</b>	
24. FUNERAL DIRECTOR <b>Arenhart Funeral Home, Inc., La Plata, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in a sealed envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the next of kin.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA E MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 09 87</b>		2b. HOUR <b>4:25 P.M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 12 93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>	
7a. BIRTHPLACE COUNTRY STATE OR FOREIGN <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES, MD</b>	
10. CITY OR TOWN OF DEATH <b>LARGO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE LARGO</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Largo</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unk</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unk.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>600 Largo Rd 20870</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N.A.</b>		17. INFORMANT <b>Nancy L. Miller</b>	
16c. ADDRESS <b>8808 Old Branch Ave.</b>		16d. ADDRESS <b>Clinton, Md 20735</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER MEDICAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Alzheimer's Disease</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
22a. I certify that (i) (this hospital) attended the deceased from <b>Sept 21, 1987</b> to <b>11/9, 1987</b> , that (i) (we) lost saw the deceased alive on <b>11-9-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE <b>Richard J. Feldman</b>		22c. DATE SIGNED <b>11/9/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD J. FELDMAN</b>		22e. ADDRESS <b>9500 ANNAPOLIS RD, LANHAM 20706</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/11/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cem</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Prince George's Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Lee Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Lindall</b>		25c. REGISTRAR'S SIGNATURE			

*[Faint, mostly illegible handwritten text and markings covering the page. Some visible fragments include:]*

*[Top left]* 10113

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*[Bottom right]* 10113

073208 NOV 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 3 3 4 0 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Effie M. Mills			2a. DATE OF DEATH MONTH DAY YEAR November 23, 1987		2b. HOUR 7:15 P.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 13 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pineview Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Weisky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Poland		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-40-5108D	
17. INFORMANT RUBY T. JONES		18. ADDRESS 10091 Washington Blvd. Laurel, Maryland		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER of BREAST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>METASTASES</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 1, 1987</u> to <u>November 23, 1987</u> , that (I) (we) last saw the deceased alive on <u>November 23, 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Stanee</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gurbux H. Nachnani, M.D.		22e. ADDRESS 8926 Woodyard Rd., #601, Clinton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/27/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		6160 Oxon Hill Rd. ADDRESS Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Fenderson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

KAREN

JANE

MLINARIC

2a. DATE KNOWN ☒ OF ESTI-  
MATED ☐ MONTH DAY YEAR 2b. HOUR  
11-19-87 M

1. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS) (LAST BIRTHDAY) 20 YRS. 7c. DATE PRONOUNCED DEAD 11-19-87 6:39a

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hampton, Virginia 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.

10. CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's County Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Maryland 13b. COUNTY PRINCE GEORGE 13c. CITY OR TOWN Forestville 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 14. STREET ADDRESS 20747 1313 Darlington Street

15. FATHER'S NAME FIRST MIDDLE LAST George Mlinaric 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anita Brandt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 577-96-2798 17. INFORMANT ADDRESS Anita & George Mlinaric Same as 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
8120 IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:09p. 11-19-87 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of an auto/auto collision 21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. 21f. LOCATION STREET CITY OR TOWN COUNTY Forestville, Md. Ritchie Rd. @ Sunnyslane

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Margaret A. Korell, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 11-19-87 EXAMINER'S NAME (TYPE OR PRINT) Margaret A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 23Nov1987 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery Clinton PG Md 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME Robert E Wilhelm ADDRESS Suitland, Md. 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 24 1987 Julia Davidson-Landale

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

18-6121 2 0 0 0-70

74023 DEC -3 1987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3408

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MARY MIDDLE B. LAST MURRAY			MONTH NOVEMBER DAY 27 YEAR 1987			3:05P M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH OCTOBER DAY 16 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital of Pr. Geo.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Co. HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST JOHN MIDDLE A. LAST BEATTY			15. MOTHER'S MAIDEN NAME FIRST JOHANNA MIDDLE LAST SCHIEDBACH			16. STREET ADDRESS / ZIP CODE 2010 LUZERNE AVENUE 20910			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-24-3546		17. INFORMANT SON ARTHUR J. MURRAY		ADDRESS 4604 QUIMBY AVENUE BELTSVILLE, MD. 20705			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-respiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> , 19 <u>87</u> , to <u>11-27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11-28/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CIRIO D. MONTGOMERY MD.</u>				22e. ADDRESS <u>3508 Dodge PK Rd Lanham MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN SILVER SPRING COUNTY MONTGOMERY STATE MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 03 1987					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

100-3385015

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DEC 03 1981

071:00 NOV 12 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE/  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33409

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST <b>Odell Frances Muse</b>			DATE ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/6 19 87</b>			HOUR <b>7:55 A.M.</b>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
<b>Female</b>	<b>Black</b>	MONTH DAY YEAR <b>Sep. 14, 1941</b>	LAST BIRTHDAY <b>46</b> YRS.	MONTHS DAYS	HOURS MIN.	MONTH DAY YEAR <b>11/6 19 87</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
<b>Washington, D.C.</b>		<b>USA</b>				<b>Prince George's County</b> MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
<b>Seat Pleasant</b>		<b>6810 Seat Pleasant Drive, #304</b>		<b>House wife</b>		<b>Own Home</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>Maryland</b>		<b>Prince George's</b>		<b>Seat Pleasant</b>		<b>6810 Seat Pleasant Drive, #304</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Otis Baker</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosalie Craddock</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>223-56-8220</b>		17. INFORMANT Apt#304 <b>Thomas H. Muse-Husband</b> Address <b>Seat Pleasant, Md 6810 Seat Pleasant</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
<b>None</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>None</b>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>None</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. <b>Deputy</b>			DATE SIGNED <b>11/6/87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>			ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery County, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<b>Burial</b>			<b>11/11/87</b>		<b>Pleasant Valley Mem. Pk.</b>		<b>Annandale, Fairfax, Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Robert B. Baker Jr.</b> ADDRESS <b>2605 S. Shirlington Arlington, Va. 22206</b>			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>			
<b>Chinn Funeral Service</b>			<b>NOV 10 1987</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

07123 12V

House

Francis

Chief



Black and white

George's family

Best friend

George's family

George's family

name

name

name

George's family

George's family

George's family



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME

FIRST

MIDDLE

LAST

Gloria Marie NAIEN

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

Oct 23 1921

2a. DATE OF DEATH

MONTH

DAY

YEAR

November 24, 1987

2b. HOUR

12:13PM

6. AGE (IN YEARS LAST BIRTHDAY)

66

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Wash.D.C.,

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

MD.

10. CITY OR TOWN OF DEATH

Lanham

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Doctor's Hospital

12a. USUAL OCCUPATION

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

PG

13c. CITY OR TOWN

College Park

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

5926 Bryn Mawr Road

14. FATHER'S NAME

Alexander

MIDDLE

Dellavalle

15. MOTHER'S MAIDEN NAME

Della

MIDDLE

Bolti

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

N/A

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

577 20 9056A

17. INFORMANT

Stephen Dellavalle (Brother)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

adventitious of right lung

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-17-87 to 11-17-87, that (I) (we) last saw the deceased alive on 11-17-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) see the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

James Harding M.D.

22e. ADDRESS

7525 Greenway Center Dr., Greenbelt, Md. 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11/30/87

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln

23d. LOCATION

Brentwood PG

Md.

24. FUNERAL DIRECTOR

Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.

25a. DATE REC'D. BY REGISTRAR

NOV 30 1987

25b. REGISTRAR'S SIGNATURE

Julia Benson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

03359 10-10-67 2050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MARY LONGO NICASTRO					NOVEMBER 11, 1987				4:00P M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE	CAUCASIAN	OCTOBER 8, 1900		87	MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
SICILY	USA			PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
COLLEGE PARK WOODS	9216 WOFFORD LANE			FURRIER		KAPLOWITZ			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MARYLAND	PR GEORGES	COLLEGE PARK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9216 WOFFORD LANE 20740		BROTHERS		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME								
ANTONINO	WOODS LONGO		MARIA ZITO						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS						
NO	577-20-0089		NUNZIO A. NICASTRO/SON/SAME AS 13						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(b)

Long-term PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1973, to 11-10-87, that (I) (we) last saw the deceased alive on 11-10-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
	M.D.	11/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
DR. HONG TEE	3415 HAMILTON STREET HYATTSVILLE, MARYLAND		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	NOV 14, 1987	GATE OF HEAVEN CEMETERY	SILVER SPRING MONTGOMERY MD
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	NOV 20 1987		
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			

157551-1215385

012011

NOV 30 1961

072264 NOV 18 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 3 4 1 2

1- STATE REGISTRAR DECLASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Donald Anthony Norcia		2a. DATE KNOWN OF DEATH ESTI- MATED Nov 9 19 87		2b. HOUR 8:16 PM	
3 SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Aug 28 32 55	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 55	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD Nov 9 19 87	2d. HOUR 1:17 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8645 Greenbelt Rd. Apt 2		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Car Repairman		12b. KIND OF BUSINESS OR INDUSTRY Amtrack	
13a. STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Norcia		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Norcia		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 578-42-8444	
17. INFORMANT Eloise Norcia, Same as Line #13		18. ADDRESS 8645 Greenbelt Rd. Apt 2		19. STREET ADDRESS 20770		20. CITY OR TOWN Greenbelt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		TITLE (SPECIFY) Dep.		MEDICAL EXAMINER		DATE SIGNED Nov 9, 1987	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS 1919 Seminary Rd., Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-10-87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 17 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PARENTHESIS AFTER ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 10-3. GIVE PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1-4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

075284 1011081

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



*[Faint handwritten text and markings in the lower section of the page, including what appears to be a signature or set of initials.]*

*[Faint text at the very bottom of the page, possibly a date or reference number.]*

073838 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1013. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33413	
1. DECEASED NAME (TYPE OR PRINT) <b>Owen Paul O'Callaghan Jr.</b>										20. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Nov 28 1987</b>	
2. SEX <b>M</b> 3. RACE <b>White</b> 4. DATE OF BIRTH MONTH DAY YEAR <b>Sept 28 1958</b> 5. AGE (IN YEARS) (LAST BIRTHDAY) <b>29 YRS.</b> 6. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN.										21. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov 30 1987</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges MD</b>	
10. CITY OR TOWN OF DEATH <b>Mt. Rainier</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3101 Queens Chapel Rd Apt 10</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Giant Food</b>											
13a. STATE <b>MD</b> 13b. COUNTY <b>Prince Georges</b> 13c. CITY OR TOWN <b>Mt. Rainier</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>3101 Queens Chapel Rd Apt 10</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Owen Paul O'Callaghan, Sr.</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucille Anne Duffy</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean 577-38-9923</b> 17. INFORMANT ADDRESS <b>7000 Nimitz Dr. N. Forestville 20747</b> <b>Laurence J. O'Callaghan, Maryland</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>19</b> 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John H. Rogers</b> M.D. TITLE (SPECIFY) <b>Dep.</b> MEDICAL EXAMINER										DATE SIGNED <b>Nov 30 1987</b>	
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>12/3/87</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Removal 11-30-87 Mt. Olivet Cem.</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wash., D.C.</b>											
24. FUNERAL DIRECTOR NAME <b>Frances Gasch's Sons Funeral Home</b> ADDRESS <b>State Anatomy Board Balto., Md.</b> 25. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>											

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NOTICE TO THE PUBLIC

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33414

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Barbara Ann O'Neal			MONTH DAY YEAR 11 29 1987			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
Female	Caucasian	Aug 22 1935	52 YRS.	MONTHS DAYS	HOURS MIN.	MONTH DAY YEAR 11 29 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.		USA		NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's County, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville		3701 Hamilton Street			Housewife		N/A	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Prince Georges		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS		
Patrick Sheeby			Helen Sheeby			3701 Hamilton Street 20782		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			N/A		James O'Neal/12001 Green Ct/Glendale, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
<i>Mario F. Golle, Jr.</i>			Assistant			11/30/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			BALTO. MD		
Mario F. Golle, Jr., M.D.			111 Penn St.			Balto. MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		23e. COUNTY
Cremation		Dec 3, 1987		Cedar Hill		Suitland		PG Maryland
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.B. Jenkins FH/7474 Landover Rd/Landover Md				DEC 07 1987		<i>Julia Davidson-Randner</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRATIONSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 7 3 3 4 1 5

1. DECEASED NAME (TYPE OR PRINT) <b>Richard Oliver</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>20</b> YEAR <b>87</b>			2b. HOUR <b>7P.M.</b>					
3. SEX <b>Male</b>		4. RACE <b>Caucassian</b>		5. DATE OF BIRTH MONTH <b>Oct</b> DAY <b>18</b> YEAR <b>1957</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co. MD.</b>					
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Never worked</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>605 4th Street 20707</b>			
14. FATHER'S NAME FIRST <b>Carl</b> MIDDLE <b>A</b> LAST <b>Oliver</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Rachael</b> MIDDLE <b></b> LAST <b>Capone</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT NAME <b>Carl A Oliver</b> ADDRESS <b>605 4th St Laurel, MD 20707</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>										<b>4 days</b>	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <b>Pneumonia</b>										<b>4 days</b>	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <b>Kern's Syndrome</b>										<b>21 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Insulin Dependent Diabetes mellitus</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>87</b> , to <b>11/20</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>BK James</b>								DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/20/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barry K. Lance, M.D.</b>								22e. ADDRESS <b>14201 Laurel Park Dr. #223 Laurel, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/23/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Laurel</b> COUNTY <b>PG</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR <b>Fleck Funeral Home Inc.</b>								25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>			
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											
2601 Sandy Spring Rd Laurel MD 20707											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Note: Records should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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072445 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR OWENS			2a. DATE OF DEATH MONTH DAY YEAR 11-06-87		2b. HOUR 6.08A M
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 03 23 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	12b. KIND OF BUSINESS OR INDUSTRY Gov.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY PG 13c. CITY OR TOWN Upper Marlboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11009 Mount Lubentia Way 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Willie Owen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arcenia Byrd		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 30 5413		17. INFORMANT ADDRESS Mack Owens-son-11009 Mount Lubentia Way	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Basal ganglia intracerebral bleed</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-1-1987</u> to <u>11-5-87</u> , that (I) <u>was</u> last saw the deceased alive on <u>11-5-1987</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> <u>did not</u> view the body after death.					
22b. SIGNATURE <u>N.S. Dhalwal</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-9-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NARINDER S. DHALIWAL</u>		22e. ADDRESS <u>P.O. Box 4, A.M.-C, CHEVERLY, MD, 20770</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 12, 1987	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4081 Benning Road, NE		25a. DATE RECEIVED BY REGISTRAR NOV 18 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH33417  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Wilholmena c. Owens</i>				2a. DATE KNOWN OF DEATH MONTH DAY YEAR 11-30 19 87				2b. HOUR M 20	
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR May 26, 1911	6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-30 19 87		2d. HOUR M 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD.			
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>P. G.</i>		13c. CITY OR TOWN <i>Clinton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>6707 Donnegan Drive 20735</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Issac Caldwell</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence Keels</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>243-30-7879</i>		17. INFORMANT <i>Ulysses Owens</i>		ADDRESS <i>5711 Gallaway Dr. Oxon Hill, Md. 20745</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ischemic (atherosclerotic) disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <i>Arthritis</i>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) M.D. <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>11-30-87</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/24/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Shiloh AME Zion Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Asheville Buncombe N. C.</i>			
24. FUNERAL DIRECTOR NAME <i>Lee Funeral Home, Inc.</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 02 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
6638 Old Alexander Ferry Rd Clinton, Md 20735									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-101. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17

(VR A15 ME)

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-01 BY 60322 UCBAW



*[Faint, illegible handwritten text, possibly a letter or document.]*

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71086 NOV-98

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
Mary Catherine Palmer

2a. DATE KNOWN OF DEATH MATED ☒ MONTH DAY YEAR 11-3 1987 2b. HOUR M

3 SEX

Female

4 RACE

White

5 DATE OF BIRTH

2-20-20

6 AGE (IN YEARS)

67 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD

11-3 1987

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Indiana

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

10. CITY OR TOWN OF DEATH

Camp Springs

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Malcolm Grow Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

At home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Pr. George

13c. CITY OR TOWN

Camp Springs

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

5900 Alely Rd/20748

14. FATHER'S NAME

FIRST MIDDLE LAST  
Martin E. Kain

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Martha E. Dillman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)  
no

16b. SOCIAL SECURITY NO.

315-10-1833

17 INFORMANT

ADDRESS  
Ralph J. Palmer, Sr. same as item 1318 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

Adenocarcinoma of the lung with metastases  
to brain, post radiation therapy

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)  
M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED 11-3-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS 5009 Rayburn Ct, Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

11/6/87

23c. NAME OF CEMETERY OR CREMATORY

CEDAR HILL CEMETERY

23d. LOCATION

Suitland

COUNTY

P.G.

STATE

Md.

24. FUNERAL DIRECTOR

NAME

G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.

25a. DATE REC'D. BY REGISTRAR

NOV 06 1987

25b. REGISTRAR'S SIGNATURE

John F. ...

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 104.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMM - 17  
(VR A15 ME (5))



071518 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL AFTER ITEM 18. GIVE FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33419	
1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST <b>Elsie Lee Paris</b>			2a. DATE KNOWN OF DEATH DATE ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/3 19 87</b>			2b. HOUR <b>12:05 P.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 3, 1922</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>65</b> YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11/3 19 87</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6044 Cipriano Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>American Legion-Greenbelt</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6044 Cipriano Road 20706</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William W. Poe</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sadie Jane Long</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>579-14-1328</b>				17. INFORMANT (Sister) <b>Ruby T. Roby</b>				5903 Berwyn Road College Park, Md. 20740			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>None</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>None</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>1919 Seminary Road</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>Silver Spring, Montgomery County, MD</b>				DATE SIGNED <b>11/4/87</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/06/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham P.G. Maryland</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>				ADDRESS <b>4739 Baltimore Avenue Hyattsville, Md. 20781</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Division of Vital Records</i>	

07/84  
25M

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(VR A15 ME (5))

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1998

James M. Smith

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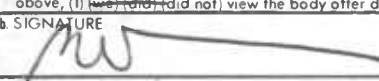
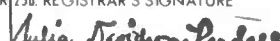
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071592 NOV

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Leonard D. Patton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 8, 1987</b>		2b. HOUR <b>11:45 PM</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 31, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Ft. Washington</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ft. Washington Rehabilitation Ctr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Model Maker-Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>Maryland Prince George Temple Hills</b>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS <b>3403 Leslie Avenue 20748</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ulysses S. Grant Patton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Ellen Newland</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-38-8931</b>		17. INFORMANT ADDRESS <b>Dorothy P. Marinari 4603 Ballad Dr. Ft. Washington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the Prostate</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Anemia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>September 82</b> , 19 <b>82</b> , to <b>November 8</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>9/23/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I did not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/9/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Philip Wisotsky, M.D.</b>		22e. ADDRESS <b>6188 Oxon Hill Rd., Oxon Hill, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/11/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Maryland</b>
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		ADDRESS <b>6160 Oxon Hill Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>	25b. REGISTRAR'S SIGNATURE 

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

051205-101

071811 NOV 16 87

Items 11, 12b, 13e, 14

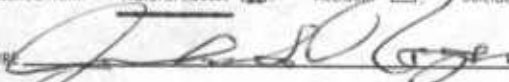
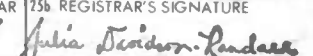
STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 3 4 2 1

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Faye</b>		MIDDLE <b>Ellen</b>		LAST <b>Pearson</b>		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/9 19 87</b>		2b. HOUR <b>M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 14, 1925</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>61</b> YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11/9 19 87</b>		2d. HOUR <b>7:45 P.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Upper Marlboro</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>18509 Queen Anne Drive Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seed Analyst</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Univ. of MD</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>18509 Queen Anne Drive</b>		Road <b>20772</b>	
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Edwin</b> LAST <b>Conner</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Rena</b> MIDDLE <b>Carpenter</b> LAST <b>Carpenter</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>476-22-7414</b>		17. INFORMANT ADDRESS <b>Barbara E. O'Brien, Same as #13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER <b>1919 Seminary Road</b>		DATE SIGNED <b>11/10/87</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>		ADDRESS <b>Silver Spring, Montgomery County, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 12, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Fairfax, Virginia</b>					
24. FUNERAL DIRECTOR <b>Beall Funeral Home</b>		ADDRESS <b>16000 Annapolis Road</b>		CITY <b>Bowie, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>		25b. REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

071811 NOV 18 87

Person

Ellen

Page

Female White Nov. 14, 1893 61

Prince George's County

Upper Harbor 1890 Green Anna White

Prince George's County Harbor 1890 Green Anna White

Household members.

None

John S. Hester, N.D.

NOV 18 1887



072702 NOV 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 3 4 2 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
WILLIE SAMUEL PEEK					11-13-87					M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. DATE DECEASED		MONTH	DAY
male	Black	April 25 1905		82 YRS.			11-13-87			12:44 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
49 Georgia		United States				Prince George's County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
100 Coral Hills		4910 Marlboro Pike				Construction		Private		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
35 Md.		P.G.		Cap. Hgts		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1105 Iago Ave 20743		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
160 Samuel		Elsa		NO		257-010-449		Amy Greenlee 1105 Iago Ave. Cap Hgts Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7999 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION						
				STREET		CITY OR TOWN COUNTY STATE				
22a. I certify that I have charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE				
Charles P. Kokes		Assistant				11-14-87				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								
Charles P. Kokes, M.D.		111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE		
Burial		11-21-87		Washington Nat.		Suitland		P.G. Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Comer-Hodges		4901 Marlboro Pk. Coral Hills Md.				NOV 20 1987		Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP 882  
 DHMH - 17  
 (VR A15 ME (5))

70 62 100 80 90 90

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
SERCAN			PENROD			NOVEMBER 6, 1987				
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH May 5, 1940				
6. AGE (IN YEARS (LAST BIRTHDAY)) 47			7. MONTH YRS.			8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's			10. CITY OR TOWN OF DEATH Camp Springs			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital AAFB				
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Agriculture Eng.			12b. KIND OF BUSINESS OR INDUSTRY Turkey Govt.			13a. STREET ADDRESS / ZIP CODE P. O. Box 20264 27619				
13a. STATE North Carolina			13b. COUNTY Wake			13c. CITY OR TOWN Raleigh				
14. FATHER'S NAME FIRST MIDDLE LAST Rasim Iz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Muffazer Unk			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A				
16b. SOCIAL SECURITY NO. 479-84-8495			17. INFORMANT Willard Penrod			18. ADDRESS Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive (70%) 3rd Degree Burns and 20% 2nd Degree Burns DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 Days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6 NOV 19 87, to 6 NOV 19 87, that (I) (we) last saw the deceased alive on 6 NOV 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE V.K. Sachdeva M.D.						22c. DATE SIGNED 6 NOV 87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINOD K. SACHDEVA, MD, MAJ, USAF, MC, FS		
22e. ADDRESS Malcolm Grow USAF Med Cen Andrews AFB, MD 20331-5300						22f. ADDRESS Malcolm Grow USAF Med Cen Andrews AFB, MD 20331-5300				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/16/87			23c. NAME OF CEMETERY OR CREMATORY Karsiyaka FH & Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Ankara Turkey	
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735						25a. DATE REC'D. BY REGISTRAR NOV 12 1987		25b. REGISTRAR'S SIGNATURE Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1361 NOV 1961

Vol. 1, No. 1

NOV 13 1961

2419 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

67 33424

1. DECEASED NAME (TYPE OR PRINT) <b>FIRST MIDDLE LAST</b> <b>ALBERT F. PERKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 16 - 1987</b>		2b. HOUR <b>9 38</b> M
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 2 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fire Inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Suitland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis A. Perkins</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Anna King</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-03-1172</b>		17. INFORMANT ADDRESS <b>Ronald F. Perkins 5400 Roblee Dr. Upper Marlboro, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE Pulmonary EDEMA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS.</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC CONGESTIVE HEART FAILURE</b>					<b>3 1/2 YRS</b>
(c) <b>DIABETIC-ARTERIO-SCLEROTIC CARDIO-VAS.</b>					<b>10 YRS.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COMBINATION SYSTEM IN PART 1 (d) <b>DISEASE</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>SEPT 83</b> , to <b>PRESENT</b> , that (I) (we) last saw the deceased alive on <b>NOV 16</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Arthur Shaver Jr MD</b>				22c. DATE SIGNED <b>11/16/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR SHAVER JR</b>				22e. ADDRESS <b>9131 PISCATAWAY RD - CLINTON MARYLAND 20735</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd Oxon Hill, Md</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1987</b>				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon copy of permit and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be certified at once.

1

73054 NOV 25 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN ALBERT PERKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 17, 1987</b>		2b. HOUR A M <b>2:30 A</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 10, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bladensburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4410 74th Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Bladensburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Albert Perkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Sands</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes-Army W.W.II</b>			
16b. SOCIAL SECURITY NO. <b>719-01-2903</b>		17. INFORMANT ADDRESS <b>Richard W. Perkins (Son) Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Compensated Congestive Heart Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from <b>11/16/87</b> 19 <b>80</b> to <b>11/16, 1987</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11/16/87</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert J. Gereige</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-17-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert J. Gereige</b>				22e. ADDRESS <b>4410 74th Ave., Landover Hills, Md. 20784</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>	
24. NAME OF FUNERAL HOME <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>			
24. ADDRESS <b>4739 Baltimore Ave., Hyattsville, Maryland</b>				25. REGISTRAR'S SIGNATURE <b>J. A. [Signature]</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.





072583 NOV 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33426

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST <b>Matthew Phillips Jr.</b>			2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>11-10 1987</b>			2d. HOUR M <b>530</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-12-37</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>50</b> YRS.		IF UNDER 1 YR. MONTHS DAYS <b>50</b>		IF UNDER 24 HRS. HOURS MIN. <b>530</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.		
10. CITY OR TOWN OF DEATH <b>Clinton</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9205 Grand Haven Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Matthew Phillips, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Gee</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>245-46-7513</b>		17. INFORMANT ADDRESS <b>Esther Littlejohn 3213 Kayson St. Silver Spring, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiorenal vasculature</b> DUE TO, OR AS A CONSEQUENCE OF DISEASE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c) <b>disease</b> DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b> M.D.						TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER			DATE SIGNED <b>11-10-87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, MD</b>						ADDRESS <b>5009 Rayburn Ct., Cp. Spr. Pr. George's Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE <b>11/14/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOVER P.G. MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>H. S. WASHINGTON + SONS 4925 BLAIRCKNS AVE</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia D. Anderson</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33427

FOR STATE REGISTRAR		DAVID		PICKERAL		LAST		REG. NO.		33427	
1. DECEASED NAME (TYPE OR PRINT)				David N/M/N Pickeral				2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11-9 1987			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-20-1938		6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hsp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Mason		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4 E. Hawthorne Dr./20646	
14. FATHER'S NAME FIRST Archie				MIDDLE		LAST Pickeral		15. MOTHER'S MAIDEN NAME FIRST Lillie		MIDDLE LAST Pickeral	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 1957-1960		17 INFORMANT 215-45-5131		ADDRESS P. O. Box 824		20601	
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)				PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic arteriosclerosis cardiovascular Disease (b) (c) DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN STREET COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 11-9-87			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez				ADDRESS 2009 Bayview Dr. Lg Spr. Ar. Geo. Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-12-87		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Geo. Md.			
24 FUNERAL DIRECTOR NAME Hunt Funeral Home				ADDRESS P. O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR NOV 12 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randner			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Frank P. Pirrone			November 20, 1987			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		
Male	Caucasian	February 4, 1912	75 YRS			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.	U.S.A.		Prince Georges			MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Camp Springs	7101 Old Branch Avenue		Repairman			Shoe		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
Maryland	Pr. Georges	Suitland	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3419 Randall Road 20746				
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.					
Antonio Pirrone	Vicenezina Pirrone		7101 Old Branch Avenue					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT					
No	577-03-1842		Joyce Shauver Camp Springs, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Biventricular Heart Failure</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>G.I. Bleed</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension, gout.</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)						
	HOUR A.M. MONTH DAY YEAR							
	P.M. 19							
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION						
WHILE <input type="checkbox"/> ON-DUTY <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK		STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> 19 <u>87</u> to <u>11-20</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11-20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Glenn R. Edgewood</u>			DEGREE <u>MD</u>			22c. DATE SIGNED		
			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			Nov. 21, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Glenn R. Edgewood			7700 Old Branch Ave Clinton Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	COUNTY STATE			
Burial	Nov. 23, 1987	Fort Lincoln Cemetery		Brentwood	P.G. Md.			
24. FUNERAL DIRECTOR			25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS			NOV 25 1987			<u>Julia Southern-Randall</u>		
Lee Funeral Home, Inc.			Clinton, Md.					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										33430	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Baby Boy</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>5 28 19 87</b>	
3. SEX <b>M</b> 4. RACE <b>B</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>unknown</b> 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>unknown</b> 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5 28 19 87</b>										2b. HOUR <b>M</b> 2d. HOUR <b>2:49A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>UNKNOWN</b> 7b. CITIZEN OF WHAT COUNTRY? <b>unknown</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>											
10. CITY OR TOWN OF DEATH <b>Landover</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9113 Taylor Street</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Prince George's County</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>MD</b>											
13a. STATE <b>MD</b> 13b. COUNTY <b>P.G.</b> 13c. CITY OR TOWN <b>Landover</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>9113 Taylor St 20785</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CASSANDRA MARIE PRICE</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO. <b>unknown</b> 17. INFORMANT ADDRESS <b>CASSANDRA Marie Price- 9113 TAYLOR ST.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION <b>5/28/87</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Drowned in toilet bowl</b> 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>XXX 5 28 19 87</b> 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5 28 19 87</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Drowned in toilet bowl</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b>house</b> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b> 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>9113 Taylor St, Landover, P.G. MD</b>											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William M. Zane</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>5/28/87</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>William M. Zane, M.D.</b> ADDRESS <b>111 Penn st. Balto.MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b> 23b. DATE <b>10-22-87</b> 23c. NAME OF CEMETERY OR CREMATORY <b>State Anatomy Board</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>											
24. FUNERAL DIRECTOR NAME ADDRESS <b>State Anatomy Board Balto., Md.</b> 25a. DATE REC'D BY REGISTRAR <b>OCT 23 1987</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Dunder-Randall</b>											

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33431  
2a. DATE KNOWN OF DEATH ☐ MONTH ☐ DAY ☐ YEAR ☐ HOUR  
11-11 1987 M1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Paul L. Linwood Price

3 SEX

Male

4. RACE

White

5. DATE OF BIRTH

Sept. 5, 1914

6. AGE (IN YEARS)

73 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

11-11 1987 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's MD

10. CITY OR TOWN OF DEATH

Cheverly

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Prince George's Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Owner/Self employ

12b. KIND OF BUSINESS OR INDUSTRY

Gas Station

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13c. CITY OR TOWN

P. G.

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

1913 Columbia Ave. 20785

14. FATHER'S NAME

Jesse Booker

15. MOTHER'S MAIDEN NAME

Jennie Mae Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

579-10-1949

17. INFORMANT

Rita I. Price

ADDRESS

Same as 13 A-E

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from: Natural causes ☐Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

11-12-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11/14/87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION (CITY OR TOWN)

Suitland

COUNTY

Prince George's MD

24. FUNERAL DIRECTOR NAME

Lee Funeral Home, Inc.

25a. DATE REC'D. BY REGISTRAR

NOV 18 1987

25b. REGISTRAR SIGNATURE

Julia Dennis

DHMH - 17

(VR A15 ME)

6638 Old Alexander Ferry Rd Clinton, Md 20735

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 5 AND 6 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

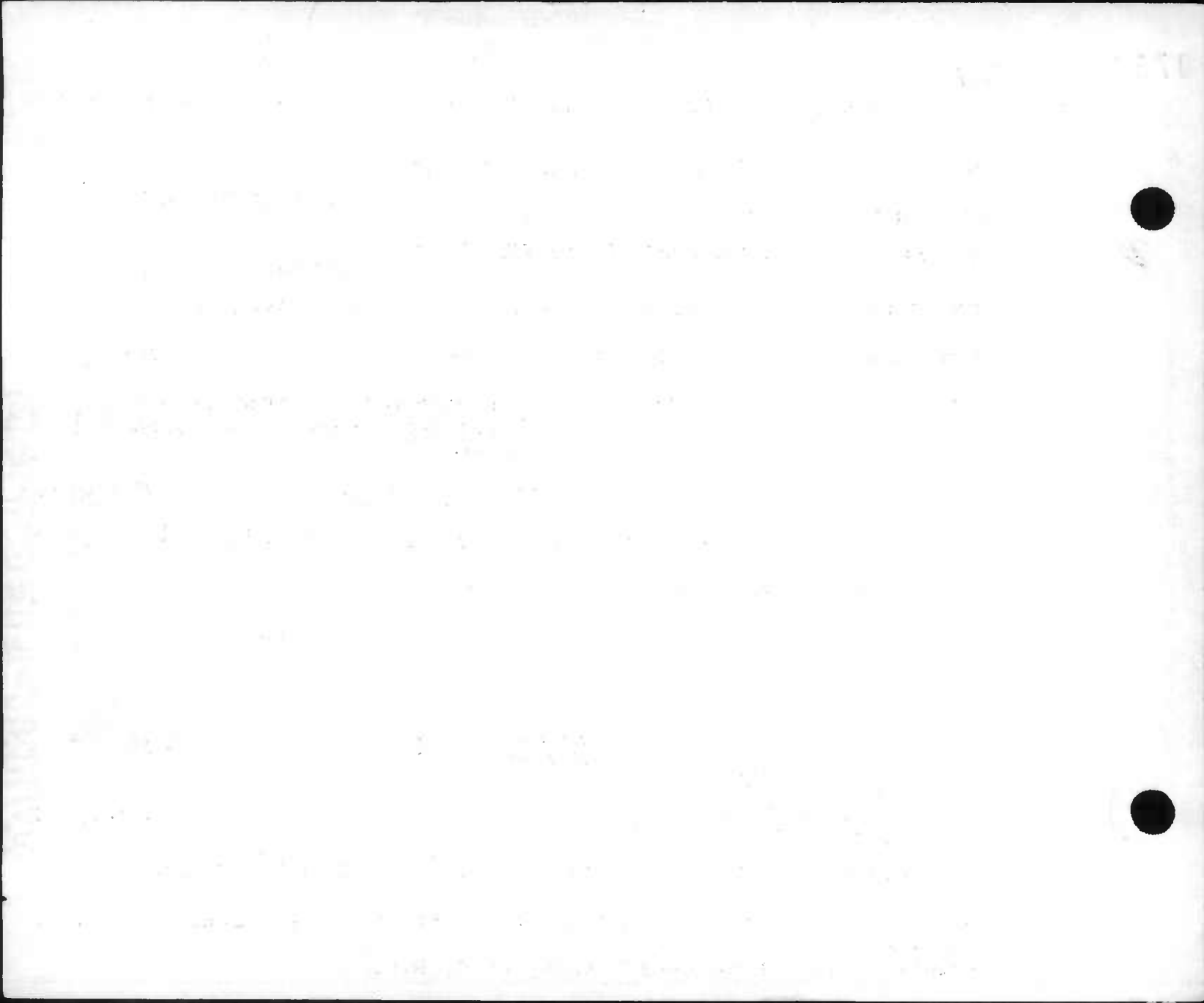
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 67 33432

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN.
AARON		F.		PROCTOR, Sr.	11-17-87				6:45AM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	Black	Aug. 24, 1911			76	MONTHS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA				PRINCE GEORGE'S COUNTY MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER				Retired		Gov't			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		P.G.	Seat Pleasant		<input type="checkbox"/> NO <input type="checkbox"/>		6904 Avon Street 20743			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Camillus			Lonnie		Harley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no			578 36 9142		Veronica Makle-daughter-9529 Temple Hills Road, Clinton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest										
DUE TO, OR AS A CONSEQUENCE OF (b) ORGANIC Heart disease 10-15 yrs +										
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung disease 10-15 yrs +										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic renal failure, Diabetes										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION				
WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME STREET FACTORY OFFICE FARM ETC.)			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1987, to 11/17, 1987, that (I) (we) last saw the deceased alive on 11/16, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			22c. DATE SIGNED				
Steven M. Pollan MD						11/17/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
Steven M. Pollan MD			7525 Greenway Ctr. Drive							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			Nov. 21, 1987		Mount Olivet Cemetery		Washington, D.C.			
24. FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Stewart Funeral Home-4001 Benning Road,			NOV. 24 1987			Julia Borden-Randall				

MEDICAL CERTIFICATION



070880 NOV-58

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 4 3 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
Charles RUSSELL				Quade, Sr.	11-1-		19	87	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	24 HOUR
MALE	WHITE	SEPT. 3, 1914	73 YRS.		11-1-		19	87	5:55 P M
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MD.	U.S.A.				Prince George's County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's General Hospital			PLANT WORKER		DAIRY		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS				
13a. STATE				13b. COUNTY	13c. CITY OR TOWN				
MD.				ST. MARY'S	MECHANICSVILLE				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS					
RICHARD C. QUADE		ALICE RUSSELL		RT. 1, BOX 540 MECHANICSVILLE, MD. 20659					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		213-18-6928		CHARLES R. QUADE, JR. MD. 20659					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries with complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		10-20-87 10-20-87		Driver in auto/pick-up truck collision					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
		road		Rt. 235 & Rt 247, Hollywood, St. Mary's Co. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED			
Charles P. Kokes		M.D. Assistant				11-3-87			
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		11-5-87		CHARLES MEMORIAL GARDENS		LEONARDTOWN, ST. MARY'S, MD.			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.		NOV 4 1987		Julia Benson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the entire

STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT JOHN QUINN SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 28 87</b>		2b. HOUR <b>6:40 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 11, 1921</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WISC.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>CHLNTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>ST. MARY'S</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY J. QUINN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GERTRUDE BERTHA MASTERSON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES WWII</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1941-1945</b>		17. INFORMANT ADDRESS <b>TARESA COBLE QUINN, SAME AS 13E.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parotid gland cancer with metastases to lungs and pleural</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>August</b> 19 <b>86</b> , to <b>Nov</b> 19 <b>87</b> that (I) (we) last saw the deceased alive on <b>11-28</b> 19 <b>87</b> , and that, in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Kai-Yin Yeung, MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-29-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kai-Yin Yeung, MD</b>		22e. ADDRESS <b>8926 Woodyard Rd #201 Clinton, MD 20735</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-02-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHELTENHAM VETERANS, CHELTENHAM, P.G. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</b>		25a. DATE REC'D BY REGISTRAR <b>DEC 01 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Seaton-Rodwell</b>		

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FOR  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33435

1. DECEASED NAME (TYPE OR PRINT) <b>Emma ETHEL Ramberg</b>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Nov 3, 1987</b>			2b. HOUR OF DEATH MIN <b>11:28</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 28 1918</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS <b>69</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov 3, 1987</b>	2d. HOUR OF DEATH MIN <b>12:28</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges MD.</b>		
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Mem Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5885 4th Ave Apt. 630</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>WELLINGTON G. BAILEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH C. SANFORD</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>220-32-5582</b>		17. INFORMANT <b>CHARLES R. RAMBERG</b>		ADDRESS <b>5540 60th AVE. RIVERDALE, Md. 20737</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Yrs</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>		
19a. DATE OF OPERATION <b>None</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D. Dep.</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>		DATE SIGNED <b>Nov 3, 1987</b>	
ADDRESS <b>1919 SEMINAR RD, SILVER SPRING</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>11-6-1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEM.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARLINGTON, ARL. CO. VA.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. W. CHAMBERS CO. RIVERDALE, Md. 20737</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1987</b>	
		25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (15))

73 01 104 3 : 4 : 70

0007-1875

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 4 3 6  
REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Louis	MIDDLE Randall	LAST Randall	2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 11-11 19 87	2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 17 29	6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-11 19 87	2d. HOUR a. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD					
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Worker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Lothian	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5227 Solomon's Island Rd		
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Randall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				
16b. SOCIAL SECURITY NO. 55-57		17. INFORMANT Gladys Randall		ADDRESS 5227 Solomon's Is		RD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 78147 IMMEDIATE CAUSE (a) Multiple Injuries with complications Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR:MIN MONTH DAY YEAR 8:27 A.M. 9/11 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) pedestrian struck by auto				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Solomons Island & Bayard Rds., Lothian, Md.				
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Anne Arundel Co., Md. death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Margareta McNeill		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 11-12-87		
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS 111 Penn St., Balto., Md.		21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/16/87		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Md.		
24. FUNERAL DIRECTOR NAME ADDRESS William Reese & Sons Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR NOV 13 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07 10 24 NOV 16 01

1041

POST 107103-202



072416 NOV 9 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33437

FOR  
1. STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)FIRST  
ClaraMIDDLE  
JLAST  
RAUMAKER

2a. DATE OF DEATH

MONTH DAY YEAR

November 15 1987

2b. HOUR

4:50 P<sub>M</sub>

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR

Nov. 8 1905

6. AGE (IN YEARS LAST BIRTHDAY)

82

YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Nebraska

7b. CITIZEN OF WHAT COUNTRY?

US

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD.

10. CITY OR TOWN OF DEATH

Riverdale

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Leland Memorial Hospital

12a. USUAL OCCUPATION

Nurses Aid (Ret.)

12b. KIND OF BUSINESS OR INDUSTRY

Nursing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

P.G.

13c. CITY OR TOWN

Laurel

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

6608 McCahill Dr. 20707

14. FATHER'S NAME

FIRST  
JacobMIDDLE  
PaulLAST  
Jacobsen

15. MOTHER'S MAIDEN NAME

FIRST  
MetteMIDDLE  
CLAST  
Christiansen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  
n/a

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)  
n/a

17. INFORMANT

506-03-2178 Evelyn Clough

ADDRESS

same as 13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest, secondary to arrhythmia

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic cardiovascular disease

Unknown

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Renal failure. Recent mesenteric thrombosis.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 2 February 19 65 to 15 November 19 87, that (I) (we) lost

saw the deceased alive on 15 November 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (b) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Carl J. Houmann

DEGREE

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐

22c. DATE SIGNED

15 Nov. 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Carl J. Houmann, M. D.

22e. ADDRESS

4404 Queensbury Rd., Riverdale, MD 20737

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)  
Burial

23b. DATE

11/18/87

23c. NAME OF CEMETERY OR CREMATORY

Meadowridge Cemetery Jessup, Howard

23d. LOCATION

CITY OR TOWN

COUNTY

STATE  
Md.

24. FUNERAL DIRECTOR

7601 Sandy Spring Road  
Fleck Funeral Home, Inc. Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

NOV 18 1987

Julia Denton-Pandora

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

01511111570

VON 1881



071573 NOV 12 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 4 3 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
ISABELLE (WMI)		RAY						11		8		19		87		1 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
F	Black	12 4 37		49 YRS.						11		8		19		87 3:20 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.		WIDOWED		DIVORCED		Prince George's								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Landover		3135 75th Avenue #4		Domestic		Private											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		Prince George's		Landover		YES		3135 75th Ave #4								20785	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Dan		Annie		Pearl		Griggs											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. ADDRESS											
No		277-46-9761		Carlton Ray		3135 75th Ave. #4										Landover, Md. 20785	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				myocardial infarction				minutes									
				Atherosclerotic Cardiovascular Disease				years									
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
Diabetes Mellitus, Hypertension																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
N/A				YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED													
N/A		N/A		N/A													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION													
N/A		N/A		N/A													
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Paul A DeVore, MD		Deputy		11-8-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
PAUL A DEVORE, MD		4203 Queensbury Rd															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		11-12-87		Harmony Memorial pk		Landover		P.G.		Md.							
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
J.B. Jenkins		NOV 10 1987		J.B. Jenkins													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

071273 NOV 15 64

071127 NOV 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH KNOWN ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
Alton			DeForest			Reed							Nov 3		19		87		3:45		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR							
M	W	Aug. 12, 24	63 YRS.			Nov 3		19		87		3:45									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH									
Washington D.C.			U.S.A.			WIDOWED			DIVORCED			Prince Georges MD									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Hyattsville			5609 Elberton Ct.			Stage Technician			Kennedy Cnt.												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Md			Prince Georges			Hyattsville			YES			5609 Elberton Ct									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT									
Thomas			Marie			Yes			579-14-1249			20 Coatbridge Court, Thomas A. Reed, Olney, Md. 20832									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Carcinoma of Mouth</u> (b) <u>Carcinoma of Mouth</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is:		
None		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>John S. Rogers</u>	TITLE (SPECIFY) <u>Doc</u> MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers</u>	DATE SIGNED <u>Nov 3 1987</u>
ADDRESS <u>1919 Seminary Road, Silver Spring, Md</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	11-03-87	Metropolitan Crematory	Alexandria Virginia
24. PREPARATION OF REMAINS NAME <u>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.</u> ADDRESS <u>4739 Baltimore Ave., Hyattsville, Md.</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Austin C. Reifke			2a. DATE OF DEATH MONTH DAY YEAR Nov. 30 1987			2b. HOUR 2:AM M		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02 16 54		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13206 Miles Court, Laurel			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Laurel								
14. FATHER'S NAME FIRST MIDDLE LAST Arthur C Reifke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Neta Lee Thompson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes Army		16b. SOCIAL SECURITY NO. 219-58-8159		17. INFORMANT ADDRESS Eugene Bovello (Friend) 5033 56th Ave. Hyatts.Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from June 11, 1987, to November 30, 1987, that (I) (we) last saw the deceased alive on September 28, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Russell Deluca MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell Deluca, MD				22e. ADDRESS 22 S. Green, Baltimore, Md. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/2/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Md.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp Ave ADDRESS S.S.Md				25a. DATE REC'D. BY REGISTRAR DEC 03 1987		25b. REGISTRAR'S SIGNATURE Julia D. D. D.		

MEDICAL CERTIFICATION

9821

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certificate pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy Evelyn Reynalds</b>			2a. DATE OF DEATH MONTH <b>11</b> - DAY <b>15</b> - YEAR <b>1987</b>		2b. HOUR <b>6:30</b> P M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>6</b> - DAY <b>9</b> - YEAR <b>1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD		
10. CITY OR TOWN OF DEATH <b>Mitchellville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Villa Rosa Nursing Home</b>		12a. USUAL OCCUPATION <b>Floral Designer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nevill's Florist</b>
13a. STATE <b>Pennsylvania</b>			13b. COUNTY <b>Lycoming</b>	13c. CITY OR TOWN <b>Montoursville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>F.</b> LAST <b>Elliot</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Derr</b> LAST <b>Derr</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN <b>No</b>		16b. SOCIAL SECURITY NO. <b>191-26-5492</b>		17. INFORMANT <b>Doris Whitney (Daughter)</b> ADDRESS <b>2110 Harbor Drive Annapolis, Md 21401</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Lymphoma.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Seizure disorder</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Stroke.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-7</b> , 19 <b>87</b> , to <b>11-15</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-15</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. Arora</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/15/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. R. Arora, M.D.</b>		22e. ADDRESS <b>14300 Gallant Fox Lane #222 Bowie, Md. 20715</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/16/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Virginia</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>			
23f. REGISTRAR'S SIGNATURE <b>Francis Gasch's Sons Funeral Home, P.A.</b>				23g. REGISTRAR'S SIGNATURE <b>Francis Gasch's Sons Funeral Home, P.A.</b>	

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Dorothy

Reynolds

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U. S. A.

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Prince George

Mitchellville Villa Rosa Nursing Home

Housewife

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CLIFFORD F. RHODES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 24 87</b>		2b. HOUR <b>5 20P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 01 01</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.		10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S HOSPITAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coal Miner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>P. George's</b>		13c. CITY OR TOWN <b>U. Marlboro</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1229 Pickering Circle/20772</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Matthew Rhodes</b>		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Turner</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unk.</b>		16b. SOCIAL SECURITY NO. <b>210-03-0058</b>		
17. INFORMANT <b>Nora R. King</b>		18. ADDRESS <b>Upper Marlboro Md.</b>		19. DATE OF OPERATION		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>URINARY TRACT INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRO VASCULAR ACCIDENT</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONGESTIVE HEART FAILURE, DIABETES MELLITUS, HYPERTENSION</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11 19 87</b> to <b>11 24 87</b> , that (I) (we) lost saw the deceased alive on <b>11 24 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>V.P. PINGCH</b>		
22c. DATE SIGNED <b>11.25.87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V.P. PINGCH</b>		22e. ADDRESS <b>5632 ANNAPOLIS RD #9 BLADENSBURG Md 20711</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-3-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dickerson Run Vanderbilt</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fayette PA</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>J.B. Jenkins 7474 Landover Rd.</b>		25. DATE REC'D. BY REGISTRAR <b>DEC 01 1987</b>		
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>						



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR			
Michael Anthony Richards			11 / 6 / 19 87			M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR		
Male	Caucasian	July 1, 1970	17 YRS.			11 / 6 / 19 87	4:50 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		U.S.A.				Prince George's County, MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Adelphi		9100 26th Ave.			Student				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland			Prince George's		Adelphi		YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			
Michael Gately			Christine Marie			215-90-6539			
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Father			Contact Gunshot Wound of Head						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			P.M. 11 / 6 / 1987			self inflicted wound			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			
			in woods at			9100 26th Ave., Adelphi, Pr. Geo. Md.			
22a. I certify that I took charge of the remains described above, held an			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion						
death resulted from			Natural causes <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			
John E. Smialek, M.D.			Chief			11/7/87			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						
John E. Smialek, M.D.			111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		23e. DATE REC'D. BY REGISTRAR	
Burial		Nov. 10, 1987		Gate of Heaven Cemetery		Silver Spring		Montgomery Md.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE			
Francis J. Collins, Jr.		500 University Blvd., W.		Silver Spring, Md. 20901		NOV 12 1987		Julia Sinden-Rudner	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERNICE M. Rigby</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10/28/87</b>		2b. HOUR MIN. <b>1045 P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>90</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Manor Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Customs</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Will Goodwin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Rigby</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. I 579-60-1480</b>		17. INFORMANT ADDRESS <b>Zoe Newbold 811 S. Taylor St. Arlington, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ATHEROSCLEROTIC CARDIORENA VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>NEPHROSCLEROTIC CARDIORENA VASCULAR DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CEREBELLAR DEGENERATION</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23, 1987</b> to <b>10/28, 1987</b> , that (I) <del>was</del> last saw the deceased alive on <b>10/28, 1987</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did not</b> view the body after death.							
22b. SIGNATURE <b>Marta Anne Schneider M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/28/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTA ANNE SCHNEIDER M.D.</b>				22e. ADDRESS <b>57401 MACARTHUR BLVD NW WASH. D.C. 20016</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Comfort Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons</b>				ADDRESS <b>Wash., D.C. 5130 Wisconsin Ave. N.W.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1987</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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- **Ex:**

## RESULTS

072391 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>E/SIE -A. ROACHE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 14, 1987</b>		2b. HOUR <b>11:40 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 24, 1905</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>81</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD.</b>
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Manor Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James - Roach</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Anne Doyle</b>		13e. STREET ADDRESS / ZIP CODE <b>4400 East-West Highway #517</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-07-6887</b>		17. INFORMANT <b>Agnes M. Marceron</b> ADDRESS <b>4400 East-West Highway #212 Bethesda, Maryland 20814</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarct</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b> <b>8 mo</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1984</b> to <b>14 Nov 1987</b> , that (I) (we) lost saw the deceased alive on <b>6 Nov 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Robert T. Kelley</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>15 Nov 87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT T. Kelley, MD.</b>		22e. ADDRESS <b>8218 Wisc. Ave. Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 18, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1987</b>		
				25b. REGISTRAR'S SIGNATURE <b>Julia Swinton-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

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100-108350



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

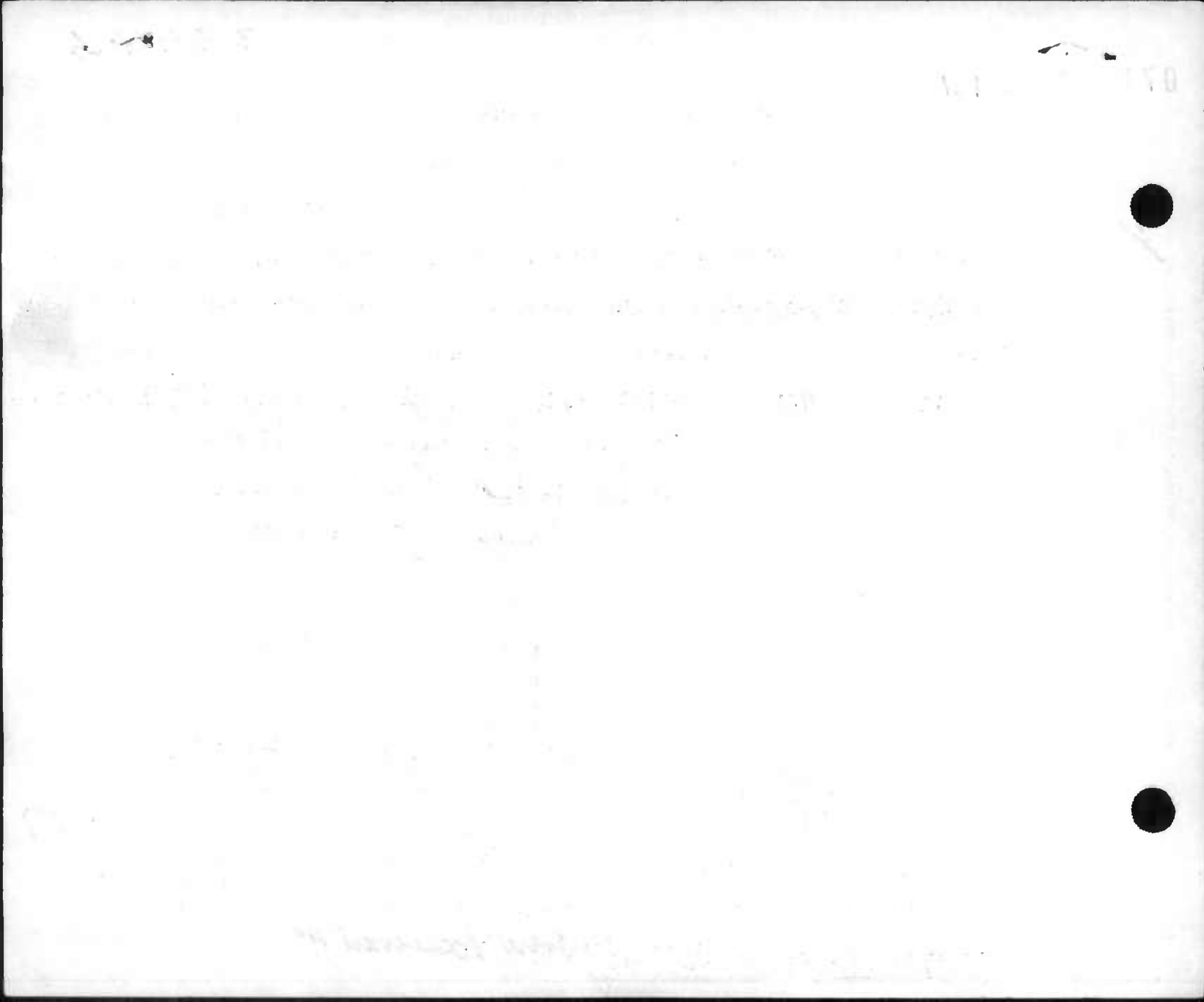
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33446  
33446

074693 DEC 11 87

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
NATHAN G ROBERTS		MALE		BLACK	
5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH 11 DAY 26 YEAR 56		31 YRS.		D.C.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		PRINCE GEORGE'S MD		CHEVERLY	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PRINCE GEORGES' HOSPITAL CENTER		Electronic Tech. Private			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	
Maryland Prince Georges Landover		YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
John E. Roberts		Irene Nickens		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). (b). (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
577-78-4828		Irene Roberts-mother		Cardiorespiratory Failure	
		Address		Metastatic Carcinoma	
		Street N W		Primary Stomach	
		818 Longfellow			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a. snore					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10 24 19 87 to 11-26 87 19 87 that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
D. Charles M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
		5632 annapolis Rd Gladwinburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Dec. 2, 1987		Harmony Mem. Park Landover, MD.	
24. FUNERAL DIRECTOR		25. REGISTRAR'S SIGNATURE		26. DATE	
Stewart Funeral Home		John T. Stewart		DEC 10 1987	
4001 Benning Road, N.E., D.C. 20019					



073482 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove checkboxes, Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified or one.

FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ellen Maria ROHLF			2a. DATE OF DEATH MONTH DAY YEAR November 25, 1987		2b. HOUR 7:00p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 20, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home
13a. STATE Michigan		13b. COUNTY Kent	13c. CITY OR TOWN Grand Rapids	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Koch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Therese Sullivan		13e. STREET ADDRESS / ZIP CODE 2100 Leonard, NE / 49505	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 323-56-1423		17. INFORMANT Anne R. Fecher, North Bethesda, MD 20852	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease 7 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Cerebrovascular disease, Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> 19 <u>86</u> to <u>11/25</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>J. M. Khatir M.D.</u>				22c. DATE SIGNED <u>11/25/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>I. M. KHATIR</u>				22e. ADDRESS <u>6525 Belcrest Road Hyattsville MD</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-30-87		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Chicago, Illinois		24. FUNERAL DIRECTOR NAME Blake-Lamb Funeral Homes 4727 West 103rd Street, Oak Park, IL 60453			
25a. DATE REC'D. BY REGISTRAR NOV 30 1987				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pandolfi</u>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 7 3 3 4 4 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

NOV 27 1987

DECEASED NAME (TYPE OR PRINT) NORA Catherine ROHRBACK			2a. DATE OF DEATH MONTH DAY YEAR 11 20 87		2b. HOUR 6:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 22 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH P.G. MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAGNOLIA GARDENS NSG HM		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Md.	13b. COUNTY PG	13c. CITY OR TOWN Bladensburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4200 Edmonston Road 20710	
14. FATHER'S NAME FIRST MIDDLE LAST William C Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Pierre		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 057-80-5077		17. INFORMANT (Son) Harold W. Rohrbach		4201 Edmonston Road Bladensburg, Md. 20710	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)
DUE TO, OR AS A CONSEQUENCE OF		(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 12/4, 19 87, to 11/20, 19 87, that (1) (we) last saw the deceased alive on 10/28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Don H. Yablonski		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	TH. DATES SIGNED 11/20/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonski		22e. ADDRESS 10300 Greenbelt Rd., #101 Seabrook, Md. 20701	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/23/87	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24. FUNERAL DIRECTOR Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Maryland 20785		25a. DATE REC'D. BY REGISTRAR NOV 25 1987	25b. REGISTRAR'S SIGNATURE Julia Bishop-Rodriguez

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

073101 NOV 27 07

NOV 25 1967

72420 NOV 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Helen Otis Rosen								11-16		19		87							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	9 4 09		78 YRS.						11-16		19		87					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
New York		USA		WIDOWED		DIVORCED		Prince George											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Clinton		7904 Westwood Court		Housewife		at home													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Pr. George		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7904 Westwood Ct. 20735											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Nathan Lee Otis		Maude Mitchell																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
no		215-38-4047		Lynne Lau		same as item 13													
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I DEATH WAS CAUSED BY:																			
888 IMMEDIATE CAUSE (a)																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																			
None displaced fracture of the nose																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
4 P.M. 10-22-87		Home		While closing the bedroom window she fell															
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21e. LOCATION		21f. CITY OR TOWN		COUNTY		STATE											
Home		3376 Curtis Drive		Sunderland		Pr. George		MD											
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED													
Augusto P. Rodriguez		Deputy				11-16-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct, Temple Hills, MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE									
Removal		11/16/87		Oakwood Cemetery		East Aurora		New York											
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		NOV 18 1987		Julia P. Rodriguez															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- STATE REGISTRAR

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 33450

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUGUSTA Teresi RUHA

2a. DATE OF DEATH MONTH DAY YEAR 11 27 87

2b. HOUR MIN 10 37 PM

3. SEX Female

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR June 25, 1912

6. AGE (IN YEARS (LAST BIRTHDAY)) 75

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD

10. CITY OR TOWN OF DEATH CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson

12b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop

13a. STATE Maryland

13b. COUNTY P.G.

13c. CITY OR TOWN Bladensburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE 4313 57th Place, #3 20710

14. FATHER'S NAME FIRST MIDDLE LAST Mariano Teresi

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Azzerillo

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 578-12-1049

17. INFORMANT (Daughter) 57th Place, #3 Agnes Mary Vickers Bladensburg, Md. 20710

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-respiratory failure

DOE TO, OR AS A CONSEQUENCE OF (b) Impaired heart function - anemia

DOE TO, OR AS A CONSEQUENCE OF (c) Fall with left femoral fracture

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Status post laparotomy for gastric perforation

19a. DATE OF OPERATION 11/15/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated viscus, trauma

19c. AUTOPSY? YES ☐ NO ☒

19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 P.M. 11 14 1987

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20b PART 1 OR PART 2) Patient fell at home

21a. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) Home

21c. LOCATION STREET CITY OR TOWN COUNTY STATE 4513 57th Ave Bladensburg Ag. Md.

22a. I certify that (I) (this hospital) attended the deceased from 11/15/87 to 11/27/87, that (I) saw the deceased alive on Nov 27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.

22b. SIGNATURE [Signature] DEGREE MD

22c. DATE SIGNED 11/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francis X. Chenno

22e. ADDRESS 14300 Gallant Fox Ln, Bowie Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 12/01/87

23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.

24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR DEC 02 1987

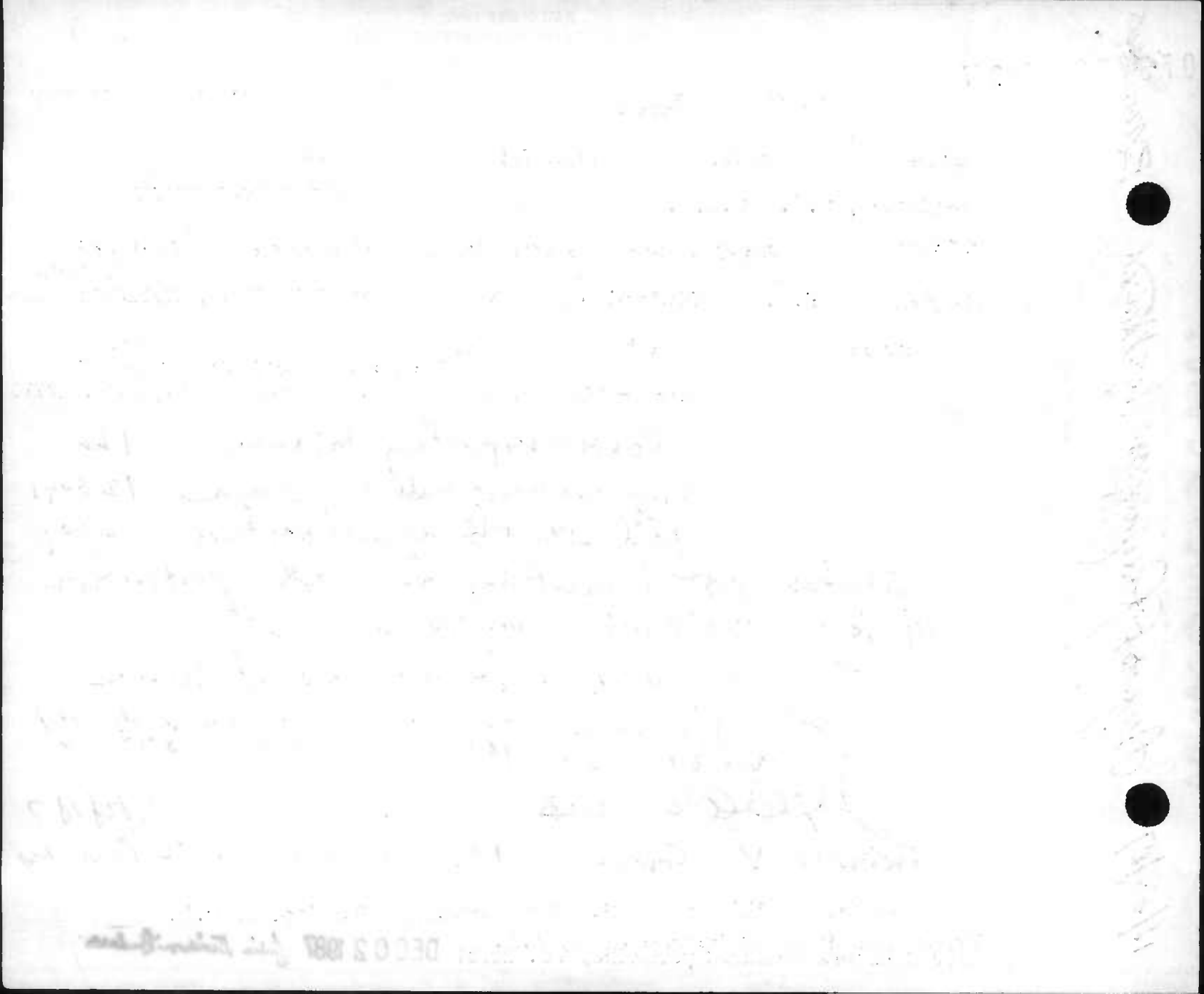
25b. REGISTRAR'S SIGNATURE [Signature]

DIVISION OF VITAL RECORDS - 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

11/28/87

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DHMH - 16 60M 7/84 (VRA 15, 4)



073425 NOV 30 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33451

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Dr. Armins</b>			MIDDLE <b>Rusis</b>			LAST			2a. DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11/24 19 87</b>			7b. HOUR <b>8:30</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 1, 1907</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>80 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11/24 19 87</b>			7c. HOUR <b>A.</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Latvia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>							
10. CITY OR TOWN OF DEATH <b>Bladensburg</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4202 - 54th Street</b>								12a. USUAL OCCUPATION (TYPE OF WORK) <b>Legal Analyst/Lawyer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Library of Congress</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince George's</b>				13c. CITY OR TOWN <b>Bladensburg</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>4202 - 54th Street / 20710</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Heinrich F. Rusis</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Feltman</b>						16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>							
16a. SOCIAL SECURITY NO. <b>577-46-3103</b>						17. INFORMANT ADDRESS <b>Mr. Robert Rusis, Son, RD.1, Box 156, Pittstown, NJ. 07867</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Acute myocardial disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). <b>chronic myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c).							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
None																			
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>1919 Seminary Road</b>				DATE SIGNED <b>11/24/87</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>Silver Spring, Montgomery County, MD</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>November 28, 1987</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>							
24. FUNERAL DIRECTOR NAME <b>Robert A. Humphrey</b>				ADDRESS <b>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>				25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM FM 37 (REtain PAGE 5 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (15))

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Male White  
11/24/67 03:30

Bladenburg  
Prince George's County, Maryland  
11/24/67 03:30

Prince George's County, Maryland  
11/24/67 03:30

Hope  
Hope

11/24/67 03:30  
1719 Seminary Road  
Silver Spring, Maryland, MD  
John ... ..  
N. D.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon and file in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 33453					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEROXIE DELRIA SALMOND										2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 18 1987				2b. HOUR 12:45PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 17 1947		6. AGE (IN YEARS LAST BIRTHDAY) 40		7. IF UNDER 1 YEAR MONTHS DAYS YRS		8. IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.									
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR. GEO.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CO. Claim Exam		12b. KIND OF BUSINESS OR INDUSTRY Private							
13a. STATE MD		13b. COUNTY PG		13c. CITY OR TOWN Largo		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 900 Falcon Drive 20772							
14. FATHER'S NAME FIRST MIDDLE LAST Albert George				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Mae Tucker				ADDRESS Upper Marlboro, MD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 223688074		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1 week</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) this hospital attended the deceased from <u>15 Nov 87</u> to <u>18 Nov 87</u> , that (2) (we) lost <u>11/18/87</u> and that (3) (our) opinion death occurred on the date and hour and from the causes stated															
22b. SIGNATURE <u>Thomas A. Bensinger MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/18/87</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger						22e. ADDRESS 7525 Greenway Center Dr. Greenbelt MD 20776									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/20/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland									
24. FUNERAL DIRECTOR NAME J.B. Jenkins/7474 Landover Rd/Maryland						25a. DATE REC'D. BY REGISTRAR NOV 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>							

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cdl  
073051 NOV 25 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SAMUEL Paul SCARLATO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-13-87</b>		2b. HOUR <b>2.52P</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 27, 1915</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. DATE OF BIRTH MONTH DAY YEAR <b>March 27, 1915</b>		
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		14. DATE OF BIRTH MONTH DAY YEAR <b>March 27, 1915</b>		
15. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>PRINCE GEORGES HOSPITAL CENTER</b>		17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cab Driver</b>		
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Cottage City</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Scarlato</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Consetti Arnone</b>		16. ADDRESS <b>4142 Bunker Hill Road</b>		
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>N/A</b>		19. INFORMANT <b>Marie Scarlato (Wife)</b>		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Natural Causes</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular Dysrhythmias,</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Seizure Disorder, Hypoxemia,</b>		21. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Pseudomonas pneumonia.</b>		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
23. DATE OF OPERATION <b>11/13/87</b>		24. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Seizure Disorder</b>		25. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/13/87</b>		28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
29. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		30. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		31. LOCATION STREET CITY OR TOWN COUNTY STATE		
32. I certify that (I) (this hospital) attended the deceased from <b>Oct 3, 1987</b> to <b>Nov. 13, 1987</b> , that (I/we) last saw the deceased alive on <b>11/13/87</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.		33. SIGNATURE <b>Stuart Turkewitz MD</b>		34. DATE SIGNED <b>11/15/87</b>		
35. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart Turkewitz MD</b>		36. ADDRESS <b>7500 Greenway Ctr. Dr. Greenbelt, Md. 20770</b>		37. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
38. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		39. DATE <b>11/18/87</b>		40. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		
41. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		42. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>		43. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, 2 and 3, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE G. SCHEIDEGGER					2a. DATE OF DEATH MONTH DAY YEAR 11 11 87			2b. HOUR 700A M	
3. SEX FEMALE		4. RACE OTHER		5. DATE OF BIRTH MONTH DAY YEAR 04 10 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) --		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7010 Greenbelt Road 20770	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Scheidegger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Etter		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 578-28-0568		17. INFORMANT ADDRESS Ernest Scheidegger 5019 56th Pl. Hyattsville, Md 20781	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>septicemic due to decubitus ulcer</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>old cerebrovascular</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 day 3 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes mellitus, seizure disorder</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1985</i> to <i>Nov 11/87</i> , that (I) (we) lost the deceased alive on <i>Nov 10/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>T. Bergemann</i>				DEGREE		22c. DATE SIGNED 11.13.87		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. BERGEMANN, M.D.				22e. ADDRESS CENTERWAY PROFESSIONAL BLDG GREENBELT, MD. 20770					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/18/87		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's MD			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <i>Lisa Sanders-Randall</i>			
6633 Old Alexander Ferry Rd Clinton, Md 20735									

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN PATRICIA SCHMITT			7a DATE OF DEATH MONTH DAY YEAR NOV 30 87		7b HOUR 8:22 P.M.
3 SEX Female	4 RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 8 30 18		6 AGE (IN YEARS (LAST BIRTHDAY)) 69	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10 CITY OR TOWN OF DEATH Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk	12b KIND OF BUSINESS OR INDUSTRY Fed. Gov't.	
13a STATE Maryland		13b COUNTY Pr. George	13c CITY OR TOWN Temple Hills	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6007 Rayburn Dr. 20748
14 FATHER'S NAME FIRST MIDDLE LAST Adam Lukasik		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Nuzsewski			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	16b SOCIAL SECURITY NO. 189-05-7461	17 INFORMANT ADDRESS Donald J. Schmitt same as item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>MULTI-SYSTEM ORGAN FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>18 NOV 87</u> , to <u>30 NOV 87</u> , that (I) <u>we</u> last saw the deceased alive on <u>30 NOV 87</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above; (I) <u>we</u> did <u>did not</u> view the body after death.					
22b. SIGNATURE <u>KJ Haar</u> MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>30 NOV 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEITH J HAAR		22e. ADDRESS Andrews Air Force Base, Maryland			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/4/87	23c. NAME OF CEMETERY OR CREMATORY Maryland Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.	
24 FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John S. ...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified of this.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

2a. DATE OF DEATH ESTIMATED Nov 14 1977		2b. HOUR 8 AM	
3. SEX F		4. RACE W	
5. DATE OF BIRTH MONTH DAY YEAR 09-07-15		6. AGE (IN YEARS) YRS. MONTHS DAYS 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oregon		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH College Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 4617 Harvard Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md		13b. STREET ADDRESS 4617 Harvard Road 20740	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Manghum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Devon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-12-2814	
17. INFORMANT Bruce Sedberry		4617 Harvard Road College Park, Md 20740	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>		
19a. DATE OF OPERATION <u>None</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Francis Gasch</u>	TITLE (SPECIFY) M.D. <u>Doc</u> MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) <u>Francis Gasch</u>	DATE SIGNED Nov 14 1977

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-16-87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons		25a. DATE REC'D. BY REGISTRAR NOV 24 1987	
25b. FUNERAL DIRECTOR'S SIGNATURE <u>Julia B. B. B.</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the county health officer, it should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel Louise Shank			2a. DATE OF DEATH MONTH DAY YEAR November 5, 1987		2b. HOUR 12:15a
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 2, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8423 58th Avenue, 20740	
14. FATHER'S NAME FIRST MIDDLE LAST John E. Burkholder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie H. Shetter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-80-7323	17. INFORMANT 8702 58th Ave., College Park, Md. Donna Carr, (undefined) 20740			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/16/87</u> 19 <u>87</u> to <u>11/4/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/3/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Abraham B. Dabela</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abraham B. Dabela, M.D.		22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md. 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-07-87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland	
24. FUNERAL DIRECTOR FRANCIS GASCH, S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 10 1987		25b. REGISTRAR'S SIGNATURE <u>James R. Rude</u>	

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (FIRST, MIDDLE, LAST) <b>CAROL M. SHEAFFER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 04 87</b>		2b. HOUR <b>9:55 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 31 1939</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>		10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		13. STREET ADDRESS / ZIP CODE <b>4617 Dallas Place 20748</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Russell Greene</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Raum</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>579 50 7791</b>		17. INFORMANT NAME ADDRESS <b>John Samuel Sheaffer Same as #13</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the breasts with metastases to the lungs, pleurae, and abdomen</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-18</b> 19 <b>87</b> , to <b>Nov</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>11-8</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Kai Yiu Yung, M.D.</b>		DEGREE		22c. DATE SIGNED <b>11-1-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kai Yiu Yung, M.D.</b>		22e. ADDRESS <b>8926 Woodyard Road #201 Clinton, MD 20735</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7 Nov 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>Bladensburg Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert E Wilhelm Funeral Home Suitland Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Frederick R. ...</b>					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on page 1 and 2 and fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOV 10 1987

071519 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33460

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE KNOWN OF DEATH		8. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH							
1. STATE REGISTRAR		Wade Ashby Shifflett		M		W		June 15, 1905		82 YRS.		Nov 4 1987		Nov 4 1987		Prince Georges MD.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE							
Virginia		U.S.A.						College Park		8500 Rhode Island Ave		Dairyman		Harvey Dairy		Md							
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter)							
Prince Georges		College Park		YES		9500 Rhode Island Avenue 20740		Otis		Myrtle E. Sprinkle		No		216-09-8880		6416 Lochridge Road Opal E. Mitchell Columbia, Maryland 21044							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
				Acute Myocardial Dis.						Chronic Myocardial Dis.						4 YRS.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
None		None		None		None		None		None		None		None		None		None					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22b. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22c. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22d. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22e. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22f. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22g. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22h. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22i. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22j. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22k. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22l. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
John S. Rogers		M.D.		Dex		MEDICAL EXAMINER		Nov 4 1987		Burial		11/07/87		Fort Lincoln Cemetery		Brentwood P.G. Maryland							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. FRANCIS GASCH'S SONS FUNERAL HOME, P.A.		27. 4739 BALTIMORE AVENUE HYATTSVILLE, MARYLAND 20781		28. NOV 10 1987		29. [Signature]							
John S. Rogers, M.D.		1919 Seminary Road Silver Spring, Md.		Francis Gasch's Sons Funeral Home, P.A.		NOV 10 1987		[Signature]		4739 Baltimore Avenue Hyattsville, Maryland 20781													

07/84  
25M

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(VR A15 ME (5))

071212 101501

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are faintly visible.]*

71964 NOV 17 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33461

1. DECEASED NAME (TYPE OR PRINT) <b>Lucille Marie SHRIVER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-12-87</b>		2b. HOUR <b>7:30AM</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 17 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Dist. of Columbia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.		
10. CITY OR TOWN OF DEATH <b>LARGO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE HEALTH CARE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>Harwood</b>		13c. STREET ADDRESS / ZIP CODE <b>4776 G. Carmody Court/20776</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin -- Withers</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude May Shelley</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-18-0021</b>		17. INFORMANT <b>4776 G. Carmody Court, Viola M. Annan-Harwood, Md. 20776</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recurrent Stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspiration Pneumonia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10-20</b> , 19 <b>87</b> , to <b>11-12</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11-12</b> , 19 <b>87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Rakesh Arora</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/13/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rakesh Arora, M.D.</b>		22e. ADDRESS <b>14300 Gallant Fox Lane, Bowie, Md. 20715</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/14/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland (Pr. Geo's) Md.</b>						
24. FUNERAL DIRECTOR <b>Richard A. Coleman Funeral Home</b>		Upper Marlboro, Md. 20772		25a. DATE REC'D BY REGISTRAR <b>NOV 16 1987</b>		
				25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Rodman</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please notify the funeral home of the death. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

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NOV 16 1984



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "A" 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33462	
1- STATE REGISTRAR		Unknown 87-112									
2a. DATE KNOWN OF DEATH		2b. DATE ESTI- MATED		2c. DATE PRONOUNCED DEAD		2d. HOUR		2e. MONTH		2f. DAY	
11-2-		11-2-		11-2-		8:35P		19		87	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Female		Black		01 23 57		30 YRS.		North Carolina		USA	
8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
WIDOWED		Prince George's County MD		Cheverly		Prince George's General Hospital		Factory Worker		Pvt	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		20785	
Maryland		Prince George		Palmer Park		YES		7807 Greenleaf Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Herbert		Emma		No		N/A		Emma Sidbury/7807 Greenleaf Road		Palmer Park, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last. (b) (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY		21f. LOCATION	
		7:44PM 11-2 1987		Passenger in auto/auto collision				road		Landover and Barlowe Roads, Landover, Prince George's County, MD	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE		TITLE (SPECIFY)								DATE SIGNED	
		M.D. Deputy Chief								11-3-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Ann M. Dixon, M.D.		111 Penn Street, Baltimore, MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Burial		Nov 11, 1987		Church Cemetery		Jacksonville Onslow NC		NOV 6 1987			
24. FUNERAL DIRECTOR NAME		ADDRESS									
J.B. Jenkins		FH/7474 Landover Rd/Landover, Md									

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(VR A15 ME (5))

100-1001 105150



0 73-825 DEC 1987

STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard Verne SIMKINS			2a. DATE OF DEATH MONTH DAY YEAR November 23, 1987		2b. HOUR 5:45AM M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Verne Simkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Audrey Maude Ousley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 042-07-5011		17. INFORMANT ADDRESS 7001 Kepner Court Josephine Simkins (Wife) Lanham, Md. 20706			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anger's Heart failure</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>87</u> , to <u>11/23</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE <u>Joseph Mathew M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/23/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Mathew				22e. ADDRESS 6510 Kenilworth Ave. Riverdale Md. 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/25/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25. DATE OF REGISTRATION DEC 02 1987 REGISTRAR'S SIGNATURE <u>Julia D. ...</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. 7506

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR  
11-12-87

21. HOUR  
4:30 P.M.

1. DECEASED NAME  
(TYPE OR PRINT) FIRST MIDDLE LAST  
Sheila Ann Simmons

3. SEX Female 4. RACE BLACK 5. DATE OF BIRTH MONTH DAY YEAR July 7, 1955 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

10. CITY OR TOWN OF DEATH Clinton 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CORRECTION OFFICER 12b. KIND OF BUSINESS OR INDUSTRY D.C. GOVT.

13a. STATE MARYLAND 13b. COUNTY P.G. 13c. CITY OR TOWN FORRESTVILLE 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 2514 RICHIE RD. 20735

14. FATHER'S NAME FIRST MIDDLE LAST LEONDUS CHAMBLISS CHAMBLISS 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORIS BROWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. N/A 17. INFORMANT ADDRESS MARYLAND DAVID SIMMONS 2514 RICHIE RD. FORRESTVILLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: Multiple Injuries

8150 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 4:00 P.M. 11-9-87 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/fixed object impact

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Temple Hills Rd. at Kirby Rd., Clinton, Prince George's Co., Md.

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 11-13-87

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 11-17-87 23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM VETERANS CEM 23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM P.G. MARYLAND

24. FUNERAL DIRECTOR J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MARYLAND 25a. DATE REC'D. BY REGISTRAR NOV 23 1987 25b. REGISTRAR'S SIGNATURE Julia Swinson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))

99% COTTON FIBER

ONE HALF DOZ



073190 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 33465	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
F. DECEASED NAME (TYPE OR PRINT) <b>Joseph Francis SIMMS, Sr.</b>										2b. DATE KNOWN OF DEATH <b>11-20 1987</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>Jan. 13, 1926</b> 6. AGE (IN YEARS) <b>61</b> 7c. DATE PRONOUNCED DEAD <b>11-20 1987</b>										2d. HOUR <b>3:07</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County</b>										10. CITY OR TOWN OF DEATH <b>Lanham</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Doctor's Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Drive</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Metro</b>	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>P.G.</b> 13c. CITY OR TOWN <b>Riverdale</b> 13d. INSIDE CITY LIMITS? <b>YES</b> 13e. STREET ADDRESS <b>5805 63rd Place 20706</b>										14. FATHER'S NAME <b>Benjamin Franklin Simms</b> 15. MOTHER'S MAIDEN NAME <b>Catherine Connor</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes-Navy</b> 16b. SOCIAL SECURITY NO. <b>W.W. II 578-24-7866</b> 17. INFORMANT <b>Celeste Simms (Wife) Riverdale, Md. 20706</b>										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemoptysis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Lung cancer + emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY <b>19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION <b>Cheltenham P.G. Maryland</b>											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b> M.D. <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>11-20-87</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez MD</b> ADDRESS <b>5009 Rayburn Court Co. Spr. P.G. Md 20748</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>11/23/87</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran's Cemetery</b> 23d. LOCATION <b>Cheltenham P.G. Maryland</b>											
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781</b> 25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1987</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Bender-Randall</b>											

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DHMH - 17  
(VR A15 ME (5))

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ST. JOHN'S BAPTIST CHURCH



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 33466

1 - FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)LAST SKOOG FIRST HAROLD MIDDLE A2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
NOV 20 1987 500 P.M.

3 SEX

Male

4 RACE

white

5. DATE OF BIRTH

MONTH DAY YEAR  
08 10 22

6. AGE (IN YEARS LAST BIRTHDAY)

65 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Nebraska

7b. CITIZEN OF WHAT COUNTRY?

USA8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges Co MD.

10. CITY OR TOWN OF DEATH

Riversdale

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Beland Memorial Hospital

12a. USUAL OCCUPATION

Plant Pathologist

12b. KIND OF BUSINESS OR INDUSTRY

US Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Prince George

13c. CITY OR TOWN

College Park13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

5026 Laguna Rd. College Pk 20740

14. FATHER'S NAME

FIRST

John

MIDDLE

August

LAST

Skoog

15. MOTHER'S MAIDEN NAME

FIRST

Albertina

MIDDLE

Pearson

LAST

Pearson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

WWII

17. INFORMANT

507-40-2353

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

Margaret L. Skoog same as #13

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

atherosclerotic heart disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

84

COUNTY

Prince Georges

STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov 20 19 87 to present 19 87, that (I) (we) last saw the deceased alive on Nov 20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Norton

DEGREE

MDATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Norton E. Norton

22e. ADDRESS

6525 Belcrest Rd Hyattsville MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

11/23/87

23c. NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory

23d. LOCATION

CITY OR TOWN

Alexandria

COUNTY

Fairfax

STATE

Virginia

24. FUNERAL DIRECTOR

Donald V. Borgwardt

4400 Powder Mill Rd.

Beltsville Md 20705

25. DATE REC'D BY REGISTRAR

NOV 25 1987

25b. REGISTRAR'S SIGNATURE

Julia DinkonTO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Paper 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0558 1 121

NOV 25 1961  
Faint handwritten text

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FREDERICK SMITH</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-19-87</b>		2b. HOUR <b>12 30PM</b>	
3a. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 24 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S HOSPITAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stock Clerk</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>							
13a. STATE <b>Md.</b>				13b. COUNTY <b>V.A.</b>		13c. CITY OR TOWN <b>Annapolis</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <b>1030 Cedar Ridge Ct. 21403</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Abraham Smith</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-30-2886</b>		17. INFORMANT ADDRESS <b>Grace Smith 1030 Cedar Ridge Ct. 21403</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple Dehiscences</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> 19 <u>87</u> to <u>11/19</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE <u>M. K. Mohan MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M-K. MOHAN</u>				22e. ADDRESS <u>6510 KENILWORTH AVE</u> <u>PRINCE GEORGE'S COUNTY MD 20737</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/23/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Md. Nat'l Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Laurel Md.</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Reese &amp; Sons Inc Annapolis, Maryland</u>				25a. DATE OF BURIAL <u>11-23-87</u>			
				25b. REGISTRAR'S SIGNATURE <u>Julia Bender-Kandace</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCILLE G SMITH			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 11 1987		2b. HOUR 7:50A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 20 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR. GEO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CO. Admin Assist		
13a. STATE Maryland		13b. COUNTY Prince Geo	13c. CITY OR TOWN Seat Pleasant	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6108 Addison Road 20743
14. FATHER'S NAME FIRST MIDDLE LAST Elijah G Gentle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah V Reynolds			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-16-3927	17. INFORMANT ADDRESS William H. Smith Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic diabetes mellitus</u>					
19a. DATE OF OPERATION 1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 9/11 to 11/11, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) I (did) (did not) view the body after death.					
22b. SIGNATURE <u>Lewis H. Dennis</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.		22e. ADDRESS 6201 Greenbelt Rd, U-17, Greenbelt, Md. 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 14Nov1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland Md.		25a. DATE REC'D. BY REGISTRAR NOV 16 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

035010 010550

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 33469

071455 NOV 20 1987

1. STATE per funeral home REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) <b>WILLIE</b>		DATE ESTI-MATED <b>10-31 1987</b>		MONTH DAY YEAR	
3. SEX <b>Male</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH <b>JUNE 27 1929</b>	
6. AGE (IN YEARS) <b>58</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE</b>		10. CITY OR TOWN OF DEATH <b>CAPITOL HTS.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>6890 WALKER MILL RD. #c1</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONSTRUCTION</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		13a. STREET ADDRESS <b>1150 51st PL. NE</b>	
13b. COUNTY <b>D.C.</b>		13c. CITY <b>WASHINGTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>FLETCHER</b>		15. MOTHER'S MAIDEN NAME <b>BLANCHE LEE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>578-60-4566</b>		17. INFORMANT <b>ADA REYNOLDS</b>		ADDRESS <b>1150 51st PL. NE. WASHINGTON D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marsue Gastrointestinal hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER DATE SIGNED <b>11-1-87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-7-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY CEMETERY</b>	
23d. LOCATION CITY OR TOWN <b>LANDOVER P.G. MARYLAND</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 09 1987</b>		23f. REGISTRAR'S SIGNATURE <b>Julia Terison-Randall</b>	
24. FUNERAL DIRECTOR NAME <b>ROLLINS FUNERAL HOME, INC.</b>		ADDRESS <b>4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

999999  
DHMH - 17  
(VR A15 ME (5))

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2030 0111 141501

2030 0111 141501

WASHINGTON, D.C. 20505  
ATTENTION: PLASMA  
FOLD TO THE HOME, IND.

NOV 01 1961

11-48



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

3 3 4 7 0

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			7b. HOUR					
Roxie CATHERINE Snably						XX			11-4 19 87			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR			
FEMALE		WHITE		AUG. 12, 1901		86 YRS.						11-4 19 87		11:19 a. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
PA.				U.S.A.								Prince George's County, MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Lanham				Doctor's Hospital				HOUSEWIFE				AT HOME					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				20785			
Md.				P.G.C.		LANDOVER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2408 VIRGINIA AVE #103,							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
LEROY E. MAY						SADIE BARDEN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT					
NO						578-05-4167D						HELEN H. SNABLY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?	
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
								STREET CITY OR TOWN COUNTY STATE									
22b. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
<i>Margarita A. Korell</i>				M.D. Assistant MEDICAL EXAMINER				11-5-87									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL				11-9-1987		FT. LINCOLN CEMETERY				BRENTWOOD, P.G.C. Md.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
W. W. CHAMBERS CO.				RIVERDALE, Md. 20737				NOV 16 1987				<i>John R. Radtke</i>					

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

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RECEIVED

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		2- DECEASED NAME (TYPE OR PRINT)		3- SEX		4- RACE		5- DATE OF BIRTH (MONTH DAY YEAR)		6- AGE (IN YEARS LAST BIRTHDAY)		7- DATE KNOWN OF DEATH (ESTI. MATED)		8- DATE PRONOUNCED DEAD		9- BALTIMORE CITY OR COUNTY OF DEATH	
1- REGISTRAR		Richard Edgar Spiess		Male		Caucasian		April 15, 1945		42 YRS.		April 19 87		11-25-87 19		Prince George's County MD.	
10- BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11- CITIZEN OF WHAT COUNTRY?		12- MARRIED (YES, NO, WIDOWED, DIVORCED)		13- BALTIMORE CITY OR COUNTY OF DEATH		14- CITY OR TOWN OF DEATH		15- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		16- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17- KIND OF BUSINESS OR INDUSTRY		18- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	
Maine		USA		WIDOWED		Prince George's County		Kettering		12400 Blk Central Avenue		Helicopter Pilot		U.S. Army		Virginia	
13a- STATE		13b- COUNTY		13c- CITY OR TOWN		13d- INSIDE CITY LIMITS?		13e- STREET ADDRESS		14- FATHER'S NAME (FIRST MIDDLE LAST)		15- MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17- SOCIAL SECURITY NO.	
Virginia		Lancaster		Lancaster		YES		Rt. 2 Box 1765		LeRoy Fred Spiess		Rita Alice Cote		Yes		213 44 5041	
18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19- PART I DEATH WAS CAUSED BY:		20- IMMEDIATE CAUSE (a)		21- DUE TO, OR AS A CONSEQUENCE OF		22- CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		23- DUE TO, OR AS A CONSEQUENCE OF		24- PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		25- 19a. DATE OF OPERATION		26- 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
Hanging																	
27- 19a. DATE OF OPERATION		28- 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		29- 20 AUTOPSY?		30- YES		31- NO		32- 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		33- 21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR)		34- 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		35- 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK	
												April 19 87		Subject hanged self			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE)		22- I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from:		23- 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from:		24- 22b. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from:	
								Woods		12400 block Central Avenue, Kettering, Prince George's County, MD		Natural causes		Accident		Suicide	
25- ACTUAL SIGNATURE		26- TITLE (SPECIFY)		27- M.D.		28- MEDICAL EXAMINER		29- DATE SIGNED		30- 11-26-87		31- EXAMINER'S NAME (TYPE OR PRINT)		32- ADDRESS		33- 111 Penn Street, Baltimore, MD 21201	
Margarita A. Korell, M.D.		Assistant															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN, COUNTY, STATE)		24- 24a. FUNERAL HOME NAME		24b. ADDRESS		25- 25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26- 26a. DATE REC'D. BY REGISTRAR	
Burial		Dec. 7, 1987		Bethel United Ceme.		Lively		Jones-Ash Funeral Home		P.O. Box 276 22473		DEC - 7 1987		J. Davidson-Randall			

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PERMIT MOTION PICTURE

WINTER 1930



DEC 1930

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 4 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARTHUR SPRAGUE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 4 1987</b>		2b. HOUR <b>8:00 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 2 04</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		
10. CITY OR TOWN OF DEATH <b>Camp Springs</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Malcolm Grow Medical Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George</b>		13c. CITY OR TOWN <b>Ft. Washington</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herbert Sprague</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Rantis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>086-18-9394</b>		17. INFORMANT ADDRESS <b>Ethel Sanchez same as item 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Asystole</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recent Myocardial Infarction</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4 November 1987</b> to <b>4 November 1987</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4 November 1987</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.						
22b. SIGNATURE <i>Edward W. Kolar</i> mp		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4 Nov 87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. KOLAR, Capt, USAF, MC</b>		22e. ADDRESS <b>Malcolm Grow USAF Medical Center Andrews AFB MD 20331-5300</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/7/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Epis. Ch. Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ft. Wash. P.G. Md.</b>						
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1987</b>				
25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

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REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33473

1. DECEASED NAME (TYPE OR PRINT) <b>Vivian M. Stanier</b>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>11-5 1987</b>			2b. HOUR M <b>3P</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 16, 1911</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>76</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11-5 1987</b>	7d. HOUR M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES CO.</b> MD			
10. CITY OR TOWN OF DEATH <b>LANHAM</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF YES, IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DOCTORS HOSP'T.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD.</b>	13b. COUNTY <b>P.G.C.</b>	13c. CITY OR TOWN <b>BOWIE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>13304 OLD CHAPEL RD. 20715</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN PHILLIPS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>579-34-3806</b>		17. INFORMANT ADDRESS <b>LINDA M. STANIER (SAME AS ITEM #13)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent colonic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Left hip fracture, pneumonia</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M./MONTH DAY YEAR <b>4 P.M. 10-28 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Slipped + fell in the bathroom</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>13304 Old Chapel Rd., Bowie, Pr. Georges Md.</b>				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>11-5-87</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>			ADDRESS <b>5009 Rayburn Ct., Temple Hills, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>11-6-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHAMBERS CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RIVERDALE, P.G.C. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO.</b>			ADDRESS <b>RIVERDALE, Md. 20737</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick R. Rader</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 101.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CARLYSLE GAINES STARK</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 10 1987</b>		2b. HOUR <b>11:41 p.m.</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 1 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Arizona</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD</b>			
10. CITY OR TOWN OF DEATH <b>Camp Springs</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Malcolm Grow Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Safety Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Andrews AFB</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Issue</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rte. 1, Box 119A 20645</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Stark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Viana Gaines</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1941-1964</b>		17. INFORMANT <b>Betty J. Stark</b>		ADDRESS <b>Rte. 1, Box 119-A Issue, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACIDOSIS AND HYPOTHERMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RUPTURED ABDOMINAL AORTIC ANEURYSM</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>10 NOV</b> , 19 <b>87</b> , to <b>10 NOV</b> , 19 <b>87</b> , that <del>we</del> (we) last saw the deceased alive on <b>10 NOV</b> , 19 <b>87</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We (we) (did not) view the body after death.</del>									
22b. SIGNATURE <i>Terence M. Quigley</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>10 NOV 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TERENCE M. QUIGLEY, MAJ, USAF</b>				22e. ADDRESS <b>MALCOLM GROW USAF MED CEN ANDREWS AFB, MD 20331-5300</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/11/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>				ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 13 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Swenson-Randall</i>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33475

FOR  
1- STATE  
REGISTRAR

2a. BASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Robert

Ray

Statham

2b. DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
11 8 19 87

2d. HOUR  
M  
11:25 P

3 SEX

Male

4 RACE

Cau.

5 DATE OF BIRTH

11-26-1928

6 AGE (IN YEARS)

58

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

11 8 19 87

2d. HOUR

11:25 P

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Indiana

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County, MD.

10. CITY OR TOWN OF DEATH

Laurel

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Greater Laurel/Beltsville Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Attorney

12b. KIND OF BUSINESS OR INDUSTRY

Self Employed

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince Geo.

13c. CITY OR TOWN

Laurel

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

8479 Imperial Drive, 20708

14. FATHER'S NAME

Ewell

Dean

Statham

15. MOTHER'S MAIDEN NAME

Agnès

Elizabeth

Knaebel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

Yes

WW-2

16b. SOCIAL SECURITY NO.

317-26-5568

17. INFORMANT

Althea J. Statham, Same as Line #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Head and chest injuries

DUE TO, OR AS A CONSEQUENCE OF

8809  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 DETAIL SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

Cerebral palsy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR 10:30 MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

Subject fell down stairs

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

home

21f. LOCATION

8479 Imperial Dr, Laurel,

CITY OR TOWN

COUNTY

STATE

MD.

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED 11/9/87

EXAMINER'S NAME  
(TYPE OR PRINT)

Charles P. Kokes, M.D.

ADDRESS

111 Penn St.

Balto.MD.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

11/14/87

23c. NAME OF CEMETERY OR CREMATORY

Nobles Chapel Cemetery

23d. LOCATION

Elberfeld

COUNTY

Warrick Indiana

STATE

24. FUNERAL DIRECTOR

FRANCIS GASCH'S SONS FUNERAL HOME, 4739 Baltimore Ave., Hyattsville, Maryland

25a. DATE REC'D. BY REGISTRAR

NOV 17 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXEMPTED WITHIN 24 HOURS AFTER DEATH OR ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

155505 141003



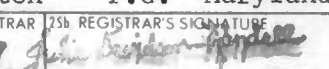
NOV 1 1987

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18a., Part #2, 21b., 22a., G-534, STATE OF MARYLAND  
 OR by Med. Ex., 12/7/87, Gbj. DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

33476

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Timothy Lee Stewart</b>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>10/ 9/ 19 87</b>		2b. HOUR M <b>8:16 P M</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 22, 1965</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>22</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>22</b>	IF UNDER 24 HRS. HOURS MIN. <b>22</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD.</b>		10. CITY OR TOWN OF DEATH <b>Oxon Hill</b>			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Woodrow Wilson Bridge (in water)</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Parts</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Forest Heights</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>58 Talbert Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James A. Stewart, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie E. Proctor</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-04-8789</b>		17. INFORMANT ADDRESS <b>James A. Stewart, Sr. 58 Talbert Dr. Forest Heights, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Cocaine and PCP use</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>10 9 19 87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject found in water</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>water</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Woodrow Wilson Bridge, Prince George's Co., Md.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Deputy Chief</b>		DATE SIGNED <b>10/12/87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/15/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.G. Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>George P. Kalas Funeral Home Oxon Hill, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1987</b>		25b. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP 817  
DHMH - 17  
(VR A15 ME (5))

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71372 NOV 10 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

S 7 3 3 4 7 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET E. MIDDLE STRICKLAND LAST			2a. DATE OF DEATH MONTH 11- DAY 2- YEAR 87			2b. HOUR 11:00 P. M.			
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH MONTH 5- DAY 9- YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OF FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD			
10. CITY OR TOWN OF DEATH Chattanooga		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. STREET ADDRESS / ZIP CODE 10010 STEDWICK ROAD #302 20879			
14. FATHER'S NAME FIRST MIDDLE LAST DAVID POORE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE Theresa Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-44-7642		17. INFORMANT ADDRESS LOUIS W. STRICKLAND, JR. / SON / SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Amputation (A.K.) right leg due to gangrene of 10/22/87</i>									
19a. DATE OF OPERATION <i>10/22/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>gangrene of foot</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>Aug</i> , 19 <i>77</i> , to <i>Nov 2</i> , 19 <i>87</i> , that (we) last saw the deceased alive on <i>NOV 2</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James J. Foster M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/3/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES J. FOSTER M.D.</i>				22e. ADDRESS <i>916 19th N.W.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE NOV 5, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25a. DATE REC'D. BY REGISTRAR NOV 09 1987		25b. REGISTRAR'S SIGNATURE <i>Kevin R. Riddle</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

The first part of the report  
 describes the general situation  
 and the results of the  
 investigation. The second part  
 contains the detailed description  
 of the methods used and the  
 results of the experiments. The  
 third part discusses the  
 results and compares them with  
 the theoretical predictions. The  
 fourth part contains the  
 conclusions and the  
 recommendations for further  
 work.

The results of the  
 investigation show that the  
 theoretical predictions are in  
 good agreement with the  
 experimental results. The  
 methods used are reliable and  
 the results are reproducible.  
 The conclusions drawn from  
 the investigation are that the  
 theoretical model is valid and  
 the experimental results are  
 reliable. The recommendations  
 for further work are to  
 investigate the effect of  
 the parameters on the  
 results and to develop a  
 more accurate theoretical  
 model.



072829 NOV 24 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST <b>ERNEST</b> MIDDLE <b>R.B.</b> LAST <b>STITH</b> <b>ERNEST R.B. STITH</b>		2a. DATE OF DEATH MONTH <b>NOV</b> DAY <b>20</b> YEAR <b>87</b>		2b. HOUR <b>958 PM</b>	
3. SEX <b>M</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>AUG</b> DAY <b>07</b> YEAR <b>1939</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>48</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PR. GEO.</b> MD.	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONTRACT MONITOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOV'T</b>

13a. STATE <b>MD</b>	13b. COUNTY <b>PG</b>	13c. CITY OR TOWN <b>CLINTON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>11105-PENNY AVE., 20735</b>	
14. FATHER'S NAME FIRST <b>LOUIS E. STITH</b> MIDDLE <b></b> LAST <b></b>		15. MOTHER'S MAIDEN NAME FIRST <b>FRANCIS CREAMER</b> MIDDLE <b></b> LAST <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1962-1964 160-32-4250</b>		17. INFORMANT <b>wife SANDRA STITH</b> ADDRESS <b>11105 PENNY AVE., CLINTON 20735</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Undifferentiated Adeno Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>87</u> , to <u>Nov 20</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Nov 20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Helen Capone</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>Nov 21-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Helen Diana CAPONE</u>		22e. ADDRESS <u>7501 SURREATTS Rd #105 Clinton Md 20735</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>25 NOV 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL PK.</b>	23d. LOCATION CITY OR TOWN <b>LANDOVER, MD.</b> COUNTY <b></b> STATE <b></b>
24. FUNERAL DIRECTOR NAME <b>ALEXANDER S. POPE</b> ADDRESS <b>2617-PA., AVE., S.E. DC 20020</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1987</b>
			25b. REGISTRAR'S SIGNATURE <u>Julia Tindler-Rudner</u>

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NOV 22 1961

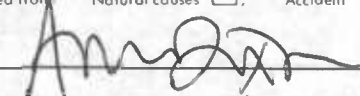
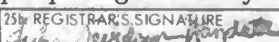
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NOV 30 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33479

1. DECEASED NAME (TYPE OR PRINT) <b>Carl Anthony Taylor</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11-24 1987</b>			2b. HOUR M <b>2:49 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 15 1971</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>16 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>16</b>	IF UNDER 24 HRS. HOURS MIN <b>16</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11-24 1987</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>
10. CITY OR TOWN OF DEATH <b>Forestville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2905 Ritchie Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Apprentice Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electric</b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Forestville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond Z. Taylor</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara E. McDonald</b>		13e. STREET ADDRESS <b>2905 Ritchie Rd. 20747</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-11-1638</b>		17. INFORMANT ADDRESS <b>Barbara E. Taylor 2905 Ritchie Rd. Forestville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? (Head Only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 11-24 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>subject shot himself</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2905 Ritchie Rd., Forestville, Prince George's Co., Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy Chief</b>		DATE SIGNED <b>11-25-87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bells United Meth. Ch. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Camp Springs Maryland</b>
24. FUNERAL DIRECTOR NAME <b>George P. Kalas</b>		ADDRESS <b>Oxon Hill Rd. Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1987</b>		25b. REGISTRAR'S SIGNATURE 

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Esther V Taylor</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 17, 1987</b>		2b. HOUR <b>6:10P<sup>M</sup></b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/13/10</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Belts. Hosp.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>				
13a. STATE <b>MD</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Laurel</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Earl Kaler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nannie Amelia Parr</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Patricia Graham 341 Brockbridge Rd. Laurel MD 20707</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE CORONARY DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/18</b> , 19 <b>86</b> , to <b>11/17</b> , 19 <b>87</b> , that (II) (we) lost saw the deceased alive on <b>11/17</b> , 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.						
22b. SIGNATURE <b>Gregory A. Compton MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-17-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY A COMPTON MD</b>				22e. ADDRESS <b>317 Cherry Lane Laurel MD 20707</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B W Crematory</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel PG MD</b>		23e. DATE REC'D. BY REGISTRAR				
24. FUNERAL DIRECTOR <b>Black Funeral Home Inc.</b> ADDRESS <b>7601 Sandy Spring RD Laurel MD 20707</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1987</b>		
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 33481

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Katheryne Young Taylor</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 05 87</b>		2b. HOUR <b>8:40 P<sub>M</sub></b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01 23 25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD</b>		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3311 Lancer Place</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dr. Office</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Prince Geo.</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3311 Lancer Place 20782</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Bis Young</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Kate McDowell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>237-34-4108</b>		17. INFORMANT <b>Warren Taylor</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic adenocarcinoma of colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b> <b>4 yrs</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>overwhelming pneumonia</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 15</b> 19 <b>87</b> to <b>Nov- 5</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Nov 5</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.)						
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Peter Pushikas</b>				22e. ADDRESS <b>11510 Old Georgetown Rd. Rockville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/09/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Silver Spring Mont. MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b> <b>4739 Baltimore Ave. Hyattsville, MD 20781</b>				25a. DATE RECEIVED BY REGISTRAR <b>NOV 10 1987</b>		
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2a. ASSESS NAME (PRINT) WALTER Clifton TAYLOR			2b. DATE OF DEATH MONTH DAY YEAR NOVEMBER 26, 1987			2c. HOUR 0300 AM													
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR JULY 31, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.											
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) process engineer		13. KIND OF BUSINESS OR INDUSTRY Singer-Link Corp								
14. CITY OR TOWN OF DEATH Laurel		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Md 17b. COUNTY Howard 17c. CITY OR TOWN Laurel			18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			19. STREET ADDRESS / ZIP CODE 9402 N. Laurel Road 20707							
20. FATHER'S NAME FIRST MIDDLE LAST Walter C. Taylor				21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie P. Brown				22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				23. SOCIAL SECURITY NO. 577 07 9496				24. INFORMANT ADDRESS Thelma L. Taylor same as above			
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Massive Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>aggravated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH within 24 hrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>acute Congestion Heart failure, Diabetes mellitus</u>																			
26a. DATE OF OPERATION <u>Swon Gump</u>		26b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>myocardial infarction</u>		26c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>N/A</u> 19 <u>87</u>		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>N/A</u>		27d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NO <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		27e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) <u>N/A</u>		27f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>	
28. I certify that (I) (this hospital) attended the deceased from <u>1985</u> to <u>11-26-87</u> , that (I) (we) last saw the deceased alive on <u>11-25-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
29. SIGNATURE <u>J. MARIANO M.D.</u> DEGREE <u>M.D.</u>												30. DATE SIGNED <u>11-26-87</u>							
31. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. JOHN C MARIANO, M.D.</u>												32. ADDRESS <u>3450 St Meade Rd #209 Laurel Md 20707</u>							
33a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		33b. DATE <u>Nov. 28, 1987</u>		33c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Lutheran</u>		33d. LOCATION CITY OR TOWN COUNTY STATE <u>Fulton, Maryland</u>		34. FUNERAL DIRECTOR NAME <u>Donaldson Funeral Home, Laurel, Maryland</u>		35. DATE REC'D. BY REGISTRAR <u>DEC 01 1987</u>		36. REGISTRAR'S SIGNATURE <u>Julia B. B. B.</u>							

07-1-1 DEC-70

073853 DEC 3 1987

1. DECEASED NAME (TYPE OR PRINT) <b>ANNE C. THALER</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 22 19 87</b>		2b. HOUR <b>7:30 AM</b>			
3 SEX <b>Female</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 13, 1935</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>52</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 22 19 87</b>		2d. HOUR <b>7:30 AM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Bowie</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8305 Cowan Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Account Clerk</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Financial</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8305 Cowan Avenue/20715</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Theodore Martinson</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude V. Brennan</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>113-22-1425</b>		17. INFORMANT <b>7561 Chrisland Avenue Lori A. Thaler Falls Church, VA 22042</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple blunt injuries of head and neck</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:00 11-22- 1987</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject was beaten.</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8305 Cowan Ave., Bowie, Prince George's, MD</b>							
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>[Signature]</i>				TITLE (SPECIFY) <b>Chief</b>				MEDICAL EXAMINER DATE SIGNED <b>11-22-87</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>John E. Smialek, M.D.</b>				ADDRESS <b>111 Penn St., Balto., MD 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>Nov. 24, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Fairfax, Virginia</b>					
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>				ADDRESS <b>16000 Annapolis Road Bowie, Maryland 20715</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 02 1987</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

013833 DEC-30-1

RECEIVED  
NOTICE  
1938

DEC 30 1938

071450 NOV 12 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 3 4 8 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST Evilyn		MIDDLE		LAST Thomas		2a. DATE OF DEATH		MONTH Nov		DAY 4		YEAR 87		2b. HOUR 10 <sup>30</sup> AM	
3. SEX F		4. RACE B		5. DATE OF BIRTH		MONTH 7		DAY 7		YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD											
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BRADFORD NURSING HOME						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER				12b. KIND OF BUSINESS OR INDUSTRY PRIVATE					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND																	
13b. COUNTY CHARLES																	
13c. CITY OR TOWN NANJEMOY																	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST DANIEL						MIDDLE						LAST THOMAS					
FIRST CARRIE						MIDDLE						LAST SIMPSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-32-7936						17. INFORMANT ADDRESS Margaret Hawkins Marbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of The uterus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 12</u> , 19 <u>87</u> , to <u>Nov 4</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost <u>Oct 8</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>[Signature]</u> M.D.																	
22c. DATE SIGNED <u>11/9/87</u>																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frank M. Ryan M.D.</u>																	
22e. ADDRESS <u>9401 Indian Head High Ft. Wash, Md 20744</u>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE NOV. 7, 1987						23c. NAME OF CEMETERY OR CREMATORY MT. HOPE					
23d. LOCATION CITY OR TOWN COUNTY STATE IRONSIDES CHARLES MD.						24. FUNERAL DIRECTOR NAME THORNTON FUNERAL HOME ADDRESS POMONKEY, MD.											
25a. DATE REC'D. BY REGISTRAR NOV 09 1987																	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signed only injury, or other traumatic event, the medical examiner must be notified and a medical certificate completed.

BP

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(VRA 15, 4) 6638

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROGER Charles Thomas			2a. DATE OF DEATH MONTH DAY YEAR 11 21 87			2b. HOUR 5:35 AM			
3. SEX M Male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Aug 15 27		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH LARGO MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE Nsg Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buildings Manager		12b. KIND OF BUSINESS OR INDUSTRY Fed. Govt.	
13a. STATE Maryland									
13b. COUNTY P. G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7905 Anne Court 20735			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Baden Thomas					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris E. James				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF IN U.S. CIVIL WAR OR OATES) WWII		17. INFORMANT ADDRESS Emily A. Thomas Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Renal Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 8/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor Debulking			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>87</u> , to <u>present</u> , 19 <u>    </u> , that (I) (we) last saw the deceased alive on <u>    </u> , 19 <u>    </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Barbara Baguk MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Baguk MD					22e. ADDRESS 5100 Auth Way, Suitland, Md 20746				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Direct Cremation			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's Md		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS Old Alexander Ferry Rd Clinton, Md 20735					25a. DATE REC'D. BY REGISTRAR NOV 25 1987		25b. REGISTRAR'S SIGNATURE <u>Barbara Baguk</u>		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Pearl V. Thorne</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 26 87</b>		2b. HOUR <b>2:30A M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 7 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>	
10. CITY OR TOWN OF DEATH <b>Forestville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Regency Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Money Examiner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Forestville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Perry Thorne</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie Taylor</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-60-5341</b>		17. INFORMANT ADDRESS <b>Catherine U. Mattingly 4007 Bedford Dr. Forestville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible Aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 mins.</b> <b>40-50 mins.</b> <b>5 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 4</b> , 19 <b>85</b> , to <b>Nov. 26</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Oct 30</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Ronald Landman</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/26/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Landman, M.D.</b>		22e. ADDRESS <b>9440 Pennsylvania Ave. Upper Marlboro, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-1-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Maryland</b>
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mildred Celia Trask</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 29, 1987</b>				2b. HOUR M <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 26, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Berwyn Heights</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8916 57th Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Berwyn Heights</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8916 57th Avenue 20740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Franz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Stoehr</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>213-56-8772</b>		17. INFORMANT ADDRESS <b>Margaret A. Keeter (Daughter) Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONGESTIVE HEART FAILURE, ANGINA, CORONARY ARTERY DISEASE</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 82</b> , to <b>PRESENT</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>NOV 26</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Eugenio S. Machado</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-30-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugenio S. Machado</b>				22e. ADDRESS <b>321 Prince George St., Laurel, Md. 20707</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/02/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Silver Spring Montgomery Md</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC - 4 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) TERRENCE GRAY TRYON			2a. DATE OF DEATH MONTH DAY YEAR NOV 14 87		2b. HOUR 11:50 PM
3 SEX M	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR DEC 3 09	6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS US	7c. CITIZEN OF WHAT COUNTRY? MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH LAUREL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15544 Plaid Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Corporate Executive		12b. KIND OF BUSINESS OR INDUSTRY Wholesale Beverage	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE New Hampshire			13c. CITY OR TOWN Franklin		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Tryon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Gray		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Son) ADDRESS 15544 Plaid Dr Richard Barrows Tryon, Laurel, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA, LUNG DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE DAY 3 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) this person attended the deceased from NOVEMBER 10 19 87 to NOVEMBER 14 19 87, that (ii) we last saw the deceased alive on NOVEMBER 13 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE BRUCE W. GATTIS		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED NOV 15, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE W. GATTIS		22e. ADDRESS 8383 CHERRY LANE LAUREL, MD. 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 1987	23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lawrence Massachusetts	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Arlington, Va. 22201		25a. DATE REC'D. BY REGISTRAR NOV 18 1987		25b. REGISTRAR'S SIGNATURE A. J. Davidson	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

1540 10/15/51

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I have" and "the" are faintly visible.]*

NOV 15 1951



074194 DEC - 78

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33490

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR											
Doris Jean Tull						11 29 87			11 29 87			M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR									
Female		White		July 11, 1920		67		MONTHS DAYS		HOURS MIN.		11 29 87		2:30									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Missouri				U.S.A.								Prince George's County MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Riverdale				Ieland Memorial Hospital								Housewife				Own Home							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								13d. INSIDE CITY LIMITS?								13. STREET ADDRESS							
13a. STATE								13b. COUNTY								13c. CITY OR TOWN							
Maryland								P.G.								Brentwood							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								3504 Upshur Street 20722							
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME								16. SOCIAL SECURITY NO.							
Alexander								Galloway								Elua Louise Black							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.								17. INFORMANT							
No								212-12-1475								James A. Tull (Son) 10704 Bodmar Avenue Poolesville, Md. 20837							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Mario F. Golle, Jr., M.D.				111 Penn St. Balto. MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				12/02/87				Fort Lincoln Cemetery				Brentwood P.G. Maryland											
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE							
Francis Gasch's Sons Funeral Home, p.A. 4739 Baltimore Avenue Hyattsville, Md. 20781								DEC - 4 1987								Julia Davidson-Kendall							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND RETURN IT TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3, BIRTH PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))

107-22 421-480

71053 NOV-6 87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE VITAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. WITHIN 72 HOURS, RETURN PAGE 5 TO THE VITAL DIRECTOR. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33491

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (FIRST, MIDDLE, LAST) JOHN Frederick UPRIGHT		2a. DATE KNOWN OF DEATH MONTH 11 DAY 01 YEAR 87		2b. HOUR M 11	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH 09 DAY 15 YEAR 1973	6. AGE (IN YEARS) 14 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH 11 DAY 01 YEAR 87
7a. BIRTHPLACE (STATE OR CITY) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student	12b. KIND OF BUSINESS OR INDUSTRY School		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY P. G.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 8401 Deborah St. 20735	
14. FATHER'S NAME FIRST MIDDLE LAST Gerald A. Upright		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anne Diegelmann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Gerald Upright Same as 13 A-E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8849 IMMEDIATE CAUSE (a) Closed head injury with intracranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 11 PM MONTH 11 DAY 01 YEAR 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) child fell out of a tree	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) yard at home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8401 Deborah St. Clinton, Prince George's, MD	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) Deputy		DATE SIGNED 11/02/1987	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Camp Springs, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/05/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR NOV 04 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
23d. LOCATION CITY OR TOWN COUNTY Clinton Prince George's Md.		25c. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

6633 Old Alexander Ferry Road Clinton, Md 20735

100-200000

RECEIVED

100-200000

100-200000

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